



FINAL REPORT ON
“REVIEW OF THE LITERATURE
ON EVALUATIONS OF OUTREACH FOR PUBLIC HEALTH INSURANCE
AND SELECTED OTHER PROGRAMS”

CONTRACT NO. 290-96-0004

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March 31, 2000

ACKNOWLEDGMENTS

This report was written by Mary Laschober, Susan Matthies, Margaret Edder, and Rachel Quinn, of Barents Group LLC of KPMG, under contract to the Agency for Healthcare Research and Quality (AHRQ), Contract No. 290-96-0004. The literature review and synthesis also was supported by the Assistant Secretary for Planning and Evaluation (ASPE), Office of the Secretary, U.S. Department of Health and Human Services. Barents Group would like to thank Peggy McNamara, Project Director at AHRQ, for her valuable direction and comments, as well as Irene Fraser, Denise Dougherty, Wendy Wolf, and the others at AHRQ who took the time to provide important input to this report.

ABSTRACT

Barents Group, funded by the Agency for Healthcare Research and Quality and the Assistant Secretary for Planning and Evaluation, conducted a literature review and synthesis of the empirically-based evidence on the effectiveness of interventions to increase enrollment of low-income children and families in public health insurance programs. The primary purpose of the literature review is to enhance our understanding of what is known, and what is yet to be known, about the types of outreach interventions that are likely to be most successful for increasing enrollment in state SCHIP and Medicaid programs. The literature review identifies and reviews nine published evaluations of outreach activities designed to increase awareness of, or enrollment in, public insurance programs. The review also identifies and describes 17 formal evaluations underway of outreach efforts to improve enrollment in Medicaid and SCHIP programs.

The literature review found that rigorous evaluations of the types of outreach activities that are frequently considered to be most effective for overcoming barriers to enrollment in SCHIP, Medicaid, or other public insurance programs are largely absent from the published literature. In addition to limited research on the effectiveness of outreach activities for the “general population” of uninsured children, research is deficient with regard to outreach strategies targeting various subgroups of children, community variables that might facilitate or mitigate outreach strategies, and the cost-effectiveness of alternative approaches. The report concludes with options for prioritizing future research in this area.

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INTRODUCTION

Background

Established as Title XXI of the Social Security Act in 1997, the State Children's Health Insurance Program (SCHIP) provides approximately \$24 billion in federal funds to states "to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children."¹ States may use this new money over the five years from fiscal year 1998 through fiscal year 2002 to expand their Medicaid programs, develop new programs, expand existing programs that provide health insurance, or use a combination of these approaches to provide health insurance to eligible uninsured children. SCHIP was created primarily to help children in working families with incomes that are too high to qualify the parents or children for Medicaid but too low for the family to afford private health insurance. By 1999, all 50 states, the five U.S. territories, and the District of Columbia had Health Care Financing Administration (HCFA)-approved SCHIP plans.²

In an effort to insure more children, up to 10 percent of the \$24 billion allocated to the states for SCHIP can be used for administration of the program and to conduct outreach to families and children to increase awareness of the program.³ Federal agencies, state agencies, and national and community-based organizations have initiated many efforts to increase the awareness of, and enrollment in, SCHIP programs. A wide range of approaches have been used, from television commercials, radio spots, bus advertisements, and placement of brochures at sports events, to local efforts including stationing outreach workers in sites such as community health centers, hospitals, shopping malls, and schools, and small group presentations in community settings.⁴ Many states have modified their application and enrollment processes to facilitate enrollment in Medicaid or SCHIP, including "butstationing" eligibility workers at locations other than welfare offices, shortening application forms, allowing mail-in, facsimile, Internet, or telephone application, eliminating the asset test and simplifying other documentation requirements, and granting presumptive eligibility.⁵ Organizations involved in outreach efforts have endeavored to involve all stakeholders in the process of outreach – from mayors, to church leaders, to school principals and nurses, to families and children themselves.⁶

The substantial amount and scope of outreach activities to enroll children into SCHIP programs would be expected to reach a large majority of eligible children. To date, however, many children thought to be eligible for SCHIP have not enrolled. According to a study sponsored by the Kaiser Commission on Medicaid and the Uninsured, as of June 1999, 1.3 million children have enrolled in SCHIP but approximately 11 million children under the age of 19 are still uninsured.⁷ Of these 11 million, it is estimated that 8 million live in households with incomes below 200 percent of the federal poverty level, which means they are likely to be eligible for

¹ Title XXI, Social Security Act, 1997, Section 2101(a).

² Health Care Financing Administration, 2000.

³ Social Security Act, 1997, Section 2025(c) (A).

⁴ Barents Group LLC, 1999; Pulos and Lynch, 1998; Mickey, 1999.

⁵ Barents Group LLC, 1999; Pulos and Lynch, 1998, Mickey, 1999.

⁶ Barents Group LLC, 1999.

⁷ Smith, 1999.

SCHIP or Medicaid coverage.⁸ A study by AHRQ researchers using the Medical Expenditure Panel Survey (MEPS) provides further evidence supporting these results. The AHRQ study found that 4.7 million uninsured children – two-fifths of all uninsured children – were eligible for Medicaid but not enrolled in 1996, before the enactment of welfare reform.⁹ The AHRQ authors also used the MEPS data and the experience of Medicaid expansion programs to predict enrollment rates under SCHIP.¹⁰ They estimated that SCHIP would be successful in enrolling only 48 percent of eligible children in 1999 unless states substantially expanded their outreach efforts. Moreover, Families USA recently reported that although SCHIP enrollment is increasing significantly in some states, these gains have been offset by reductions in children's Medicaid coverage largely due to welfare reform. In 1999, fewer children in the 12 states with the largest number of uninsured children were enrolled in Medicaid and SCHIP programs combined than were enrolled in Medicaid alone in 1996. The number of poor children declined in 1998, but the number of poor children without health insurance did not.¹¹

Purpose of the Study

These numbers leave policymakers questioning why more families have not insured their eligible children. Research into this issue has found that families often face a variety of barriers that dissuade them from completing SCHIP and Medicaid applications. Although research has also suggested that many of these barriers can be overcome through appropriate interventions, it is frequently unclear which activities would be most effective for overcoming particular barriers to enrollment, which populations the activity is likely to be most effective for, and how the specific circumstances or characteristics of a particular community might make the outreach activity more or less successful.

The Agency for Healthcare Research and Quality (AHRQ, formerly the Agency for Health Care Policy and Research) contracted with Barents Group LLC of KPMG to conduct a literature review and synthesis of the empirically-based evidence on the effectiveness of interventions to increase enrollment of low-income children and families in public health insurance programs. The primary purpose of the literature review is to enhance our understanding of what is known, and what is yet to be known, about which outreach interventions are likely to be successful for increasing enrollment in SCHIP and Medicaid programs. To answer these questions, we primarily reviewed evaluations of outreach interventions published in peer-reviewed journals, but we also reviewed unpublished evaluation studies sponsored by federal and state agencies. Because low-income families are likely to face many of the same barriers to enrolling in means-tested programs such as Food Stamps and the Social Security Income program as they are to enrolling in Medicaid and SCHIP, we also examined evaluations of interventions to increase enrollment in comparable means-tested programs. Public health insurance and means-tested programs included in the review are Medicaid; SCHIP; Temporary Assistance for Needy Families (TANF) and Aid for Families with Dependent Children (AFDC); Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); Food Stamps; the National School

⁸ Henry J. Kaiser Family Foundation, 1999.

⁹ Selden, Banthin, and Cohen, 1998.

¹⁰ Selden, Banthin, and Cohen, 1999.

¹¹ Pulos, 1999.

Lunch Program (NSLP); Early and Periodic Screening, Diagnosis and Treatment (EPSDT); Social Security Income (SSI); the Head Start program; and Medicare.¹²

The goal of this literature review is to collect, assess, and synthesize the results from rigorous empirically-based evaluations of outreach interventions that have proven to be effective or ineffective for increasing enrollment in public insurance programs, and to identify why such interventions have or have not been effective. The report also describes currently funded, but not yet completed, evaluations of outreach interventions to increase enrollment in Medicaid and SCHIP. By reviewing completed, on-going, and planned outreach evaluations, the review has identified major gaps in the research on effective outreach for public insurance programs. The gaps will help to guide research agendas for federal, state and local agencies, foundations, and other interested organizations.

Definitions of Outreach

“Outreach” for public insurance programs is a very broad term, but is fundamentally comprised of efforts to increase enrollment in the desired program. The following are examples of commonly used definitions in the literature on improving outreach for the SCHIP program:

- ◆ “Outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs to inform these families of the availability of, and to assist them in enrolling their children in, such a program.”¹³
- ◆ “Title XXI defines outreach as the process of identifying and reaching out to low income children in order to enroll them in health insurance coverage which may be made available through expanded Medicaid or a state designed insurance program.... [O]utreach activities that can be funded under Title XXI include, but are not limited to, eligibility screening, activities conducted by outstationed eligibility workers, and other efforts designed to enroll children in health insurance programs. Also defined as outreach are certain enabling services that help to ensure that insured children are able to access necessary health care services. Enabling services help to remove the cultural, linguistic, economic, geographic, and education barriers that impede access to care and may include health education, transportation, translation, home visiting, or mobile clinic services.”¹⁴
- ◆ “Children’s health insurance outreach is a dynamic process in which broad networks of concerned Americans work together to identify, educate and enroll uninsured children in Medicaid or SCHIP....Activities that could increase enrollment in health insurance programs include advertising on bill boards, television and radio; sending messages in simple language and in multiple languages; using toll-free hotlines to answer questions and enroll individuals; spreading the word through community health advocates, children’s agencies, parents’ networks and religious groups and targeting uninsured children where they spend most of their time: in schools, child care settings, and Head Start sites. Outreach also involves Federal and State efforts to streamline the application and enrollment process by shortening forms, accepting mail-in applications, reducing processing time, and placing eligible workers

¹² Throughout this document, this set of programs is referred to as “public insurance programs.”

¹³ Title XXI, Social Security Act, 1997, 2102(c)(1).

¹⁴ Health Resources and Services Administration and the Health Care Financing Administration, 1998.

in convenient locations. Use of a joint application form for different programs can also enhance coordination of resources across programs serving the same children.”¹⁵

- ◆ Outreach is “a service or complement of services for actively reaching patients in their own environments and communities to increase access to care and result in improved health outcomes.”¹⁶
- ◆ “Outreach [is] making *meaningful* contacts with [clients] on *their* terms in *natural* settings within well-defined communities, while also providing any service that facilitates entry into the [program]. Almost by definition outreach means leaving the confines of the health department to take messages and services to the people who need them.”¹⁷
- ◆ “In the simplest sense, it [outreach] entails sharing an important message with a large audience. But effective outreach must go further than raising public awareness. It must motivate the audience to take some action.”¹⁸
- ◆ According to a Families USA report, SCHIP legislation defines outreach as “activities to inform families of available coverage programs and to assist them in enrolling.”¹⁹
- ◆ A form of outreach, often referred to as “inreach,” can also be considered part of outreach activities.²⁰ Inreach takes advantage of having potential eligible families or children in a location where they might be considered a “captive audience.” Instead of reaching out, the reach is inward to a population that is already part of a system, such as a primary care physician’s office, a health clinic, work sites, or hospitals. A prime example of inreach for the SCHIP/Medicaid eligible population is schools.

Typology of Outreach Steps

The above definitions encompass a basic concept: outreach can be considered any activity along the continuum of identifying people who are potentially eligible for a public insurance program, making them aware of the program and their possible eligibility, enrolling them in the program if eligible, and ensuring they continue in the program and receive appropriate services. Based on the above definitions, we have classified outreach into nine discrete steps, described below, that are part of a process to move people from awareness to actual enrollment or use of services.

Beneath each outreach step, we list examples of the most common enrollment barriers identified in the literature that require outreach interventions to overcome those barriers.²¹ Findings from surveys, in-depth and expert interviews, focus groups, and observational research reveal that barriers to enrollment are varied and numerous, interact in complex ways, and occur at each stage of the process from awareness to use of services. It is possible to overcome some barriers through better communication (such as awareness and information barriers), while others require

¹⁵ Report to the President, 1998.

¹⁶ Health Resources and Service Administration Bureau, 1998.

¹⁷ Centers for Disease Control and Prevention, 1997.

¹⁸ Center on Budget and Policy Priorities, 1998.

¹⁹ Pulos and Lynch, 1998.

²⁰ Centers for Disease Control and Prevention, 1997.

²¹ See, for example, Perry, Stark, and Valdez, 1998; Brecht Carpenter and Kavanagh, 1998; Pulos and Lynch, 1998; Schwalberg, et al., 1999; DeChiara and Wolff, 1998; General Accounting Office, 1999; Children’s Defense Fund, 1999; Academy for Educational Development, 1999; Feld, Matlock, and Sandman, 1998.

changes in the system (such as allowing self-declaration of assets and income), while still others require one-on-one assistance to overcome (such as transportation, child-care, or help in translating documents for non-English speakers). Different groups of people have different types of barriers (e.g., non-English speakers often face a language barrier, rural people may have substantial transportation barriers), which necessitate different outreach approaches. Along with examples of common barriers, we also list the most common outreach interventions that have been promoted as being potentially effective for decreasing barriers and increasing enrollment and access to services.²²

Step 1. Identify and understand the potentially eligible population. The first step in designing effective outreach activities to improve enrollment or use of services in public insurance programs is to identify the target population(s) and then understand their barriers to enrollment and services. It involves obtaining detailed information about the socio-economic, demographic, psycho-graphic, and other pertinent characteristics of the eligible but unenrolled target populations. This outreach step uses formative research that is crucial for identifying barriers to enrollment and use of services in order to develop messages, materials, and ways of implementing outreach interventions that are likely to be most effective for overcoming these barriers.

Step 2. Increase public awareness that the program exists. This step encompasses outreach interventions to ensure that the target population, as well as others who can assist them with enrollment, are aware of the public insurance program. Awareness precedes any outreach efforts to enroll people into programs.

Example of barriers: Lack of publicity; lack of publicity targeted towards individuals with low literacy or reading skills; lack of publicity targeted towards individuals who do not speak English; other pressing daily needs that compete for the attention of the target population.

Example of interventions: Promote partnering and referrals (partner with other public and private organizations to increase resources – knowledge, financial support, in-kind services); establish toll-free hotlines; promote PSAs/advertisements on radio, TV, and in print media; use newsletters and direct mailings;

Step 3. Increase understanding of eligibility for the program. The target population, and others who can assist them with enrollment, must not only be aware that the program exists, they must also realize that they are potentially eligible for the public insurance program. Without this understanding, members of the target population are not likely to take action to find out more about the program.

Example of barriers: Confusion about eligibility for a particular program because of the many programs with different eligibility criteria targeted toward the same population; poorly-designed materials that do not make clear who is eligible; inconsistencies in terminology and eligibility requirements; lack of self-identification as being “low-income”; language and cultural barriers.

²² See, for example, Brecht Carpenter and Kavanagh, 1998; Center on Budget and Policy Priorities, 1998; Brecht Carpenter and Kavanagh, 1997; Cohen Ross, 1999.

Example of interventions: Distribute simple and clear brochures/flyers/posters; translate materials into non-English languages; ensure that materials are culturally appropriate for the target population; provide consistent training to all eligibility workers in state/county about details of program; appoint a single person in the welfare office to be very knowledgeable about a specific program; standardize eligibility rules across different public insurance programs;

Step 4. Educate individuals about the program. This step encompasses those outreach activities that are designed to educate the target population, and others who can assist them with enrollment, about the benefits the program has to offer. It includes making the target population aware of ways that the program is relevant and important to their daily lives to increase their interest in enrolling.

Example of barriers: Belief that health insurance is not important; lack of time to understand program's benefits due to other pressing daily needs; fear of losing other public or private benefits; immigration and "public charge" fears.

Example of interventions: Conduct "inreach" at schools, hospitals, work-sites, etc.; train outreach workers, intermediaries, and eligibility workers about details of program; organize small group presentations; clarify immigration and public charge issues; use trusted individuals and community organizations to educate individuals about benefits of program and allay fears.

Step 5. Motivate individuals to take action to find out more about, or enroll in, the program. Once eligible individuals have learned about the program, they often need to be motivated to seek more information on the program or to actually enroll. Motivational activities may be very different from educational activities. Educational activities mainly involve informing individuals about the program; motivational activities are designed to capture people's interest and make them want to change their current behavior to the desired behavior.

Example of barriers: "Welfare program" stigma; concern that government programs are inferior in quality to private insurance; belief that effort of applying outweighs program benefits.

Example of interventions: Use names for Medicaid and other public insurance programs that disassociate them from "welfare"; issue "private-type" insurance cards; approve alternative enrollment sites to welfare offices; provide tangible incentives (vouchers, coupons, etc.); develop effective and appropriate messages; use peer/role model/community-based outreach or case management/advocacy system to instill trust and credibility with the target population; inform individuals that they can receive personal assistance with completing the application process.

Step 6. Facilitate individuals' actions needed to enroll in the program. As much as some people may want to enroll in a program, they may find that the difficulties of enrolling outweigh their benefits from the public insurance program. The next outreach step is to make the process of enrolling or taking an action feasible for the eligible population.

Example of barriers: Lack of required documentation; fear of discrimination; lack of transportation or child care; inability to take time off work to go to welfare office; language and translation issues; reluctance to disclose personal information.

Example of interventions: Have an outreach worker sit down and help individuals fill out a SCHIP or Medicaid application; arrange for transportation to an enrollment site; trouble-shoot with state welfare or other agency staff; provide one-on-one application assistance at places where families feel comfortable (schools, churches, day care centers); provide case management, home visiting, tracking and follow-up assistance.

Step 7. Address systemic barriers to enrollment or action. There are often barriers to enrollment that outreach workers or better communications and education simply cannot address. Barriers that arise from the way in which application, enrollment, or access to care systems work must be addressed by changes to these systems. Outreach interventions related to this step are those designed to making enrollment easier under the federal and state systems currently in place.

Example of barriers: Cumbersome application process; hard-to-access enrollment sites; inappropriate denials; poor customer service; English language difficulties.

Example of interventions: Reduce the length and complexity of application forms; translate forms into non-English languages; have multi-lingual staff capabilities at welfare intake offices and out-stationing sites; remove social security numbers from applications; allow self-declaration of income and assets; use a single application for Medicaid and SCHIP; approve alternative enrollment sites to welfare offices, methods (mail-in applications, telephone interviews), and times (weekends and evenings); approve out-stationing of eligibility workers; improve customer service at the welfare office.

Step 8. Change state policies and program characteristics to address barriers. This step to increasing enrollment is more policy-oriented. It includes changing laws, regulations, and policies that act as barriers to enrollment in public insurance programs

Example of barriers: Long delays from time of application to receipt of benefits; inconsistent eligibility rules and application procedures across states; inconsistent eligibility rules and application procedures across public insurance programs and for different members of the same family.

Example of interventions: Adopt presumptive or expedited eligibility; grant 12-month continuous eligibility; improve data and information systems; federalize Medicaid/SCHIP programs; standardize Medicaid, SCHIP, and other public insurance program eligibility across states and across family members.

Step 9. Address access to care and use of services after enrollment. This step includes outreach interventions that are designed to ensure that individuals who enroll in public insurance programs have access to necessary care and understand how to access and use the health care services they need.

Example of barriers: Lack of follow-up by program or health care workers to explain benefits; inadequate supply of health care providers and facilities; lack of transportation or child care; language, literacy, and cultural barriers.

Example of interventions: Provide incentives for providers and facilities to locate in underserved areas; provide incentives for providers to serve public insurance program recipients (e.g., pay higher fees); require managed care and other providers to inform recipients of program benefits; design simple, clear, and easy-to-understand materials that explain program benefits; translate materials into non-English languages and use culturally-relevant approaches; use case management to coordinate individuals' care; provide transportation and child care vouchers; locate providers and facilities near target populations.

The above typology is used to classify evaluations of outreach interventions. For each study reviewed, we determined the step or steps of the typology that were the primary focus of the outreach intervention(s) evaluated (see Table 1 in Appendix A). Because the purpose of this report is to examine interventions designed to enroll uninsured children in public insurance programs, we have not addressed interventions designed to increase access to care and use of services subsequent to enrollment. In addition, step 1 (“identify and understand the potentially eligible population”) consists primarily of formative, rather than evaluative, research so studies with this focus are not included in the review. Studies selected for this literature review and synthesis are those that provide rigorous, empirically-based evaluation of the effectiveness of outreach interventions that address outreach steps 2 through 8 to increase enrollment in public insurance programs. The following section describes in more detail our literature search methodology and the criteria used to select studies for the review.

LITERATURE SEARCH, SELECTION, AND REVIEW METHODOLOGY

This section of the report describes the process and methodology we used to conduct an extensive literature search, and the methodology we employed to select studies to review for the literature synthesis. The bibliography contains a complete listing of all the articles, papers, and studies we collected and reviewed for this report.

Literature Search Method

The literature search initially was very broad: we searched for articles and reports that included an evaluation of an outreach activity related to public health insurance or comparable means-tested public programs or to public health initiatives. The search included electronic databases, potentially relevant journals not included in the databases, the Internet, and other sources (e.g., key informants).

Step 1: Electronic databases. Barents first conducted an extensive literature search of the following relevant bibliographic electronic databases²³ to identify published studies in peer-reviewed journals that evaluated outreach interventions to promote public health objectives or facilitate enrollment in public insurance and comparable means-tested programs. Only English-language articles and articles concerning U.S. programs were selected for further review. Databases searched were:

- ◆ MEDLINE,²⁴
- ◆ GENMED,²⁵
- ◆ HealthStar,²⁶
- ◆ CINAHL,²⁷ and
- ◆ HSRProj.²⁸

²³ Relevance was based on the defined scope and subject matter of the database, i.e., the database covers publications relating to public health, public health insurance, means-tested public programs, health policy, health economics, or general evaluations of government or public health programs.

²⁴ The Medline library contains bibliographic information from the National Library of Medicine for more than 3500 worldwide clinical and research journals dating back to 1966.

²⁵ The General Medical Library (GENMED) contains full-text medical journals and newsletters, as well as information on drug interactions, cancer, poison, disease, trauma, and medical administration.

²⁶ The Health Services, Technology, Administration and Research (HealthStar) database contains bibliographic citations of journal articles, technical and government reports, meeting papers and abstracts, books and book chapters on clinical (emphasizes the evaluation of patient outcomes and the effectiveness of procedures, programs, products, services, and processes) and non-clinical (emphasizes health care administration and planning) aspects of health care delivery. HealthStar also comprises bibliographic records from MEDLINE (1975 to present) and unique records from the following sources: records emphasizing health care administration selected and indexed by the American Hospital Association (AHA); records emphasizing health planning from the National Health Planning Information Center; and records emphasizing health services research, clinical practice guidelines, and health care technology assessment selected and indexed through NLM's National Information Center on Health Services Research and Health Care Technology (NICHSR).

²⁷ The Cumulative Index to Nursing and Allied Health Literature (CINAHL) database contains abstracts and full-text articles from over 1200 nursing and allied health related journals. The search of CINAHL was undertaken after the earlier searches. A decision had been made to exclude the public health literature by that time so the search terms for CINAHL were more limited. No additional articles for review were identified through this search.

The following key words and phrases were used to search the electronic databases:

- ◆ Evaluation,
- ◆ Outreach,
- ◆ Impact,
- ◆ Outcomes,
- ◆ Pilot project,
- ◆ Demonstration,
- ◆ Enrollment,
- ◆ Evaluation of outreach activities,
- ◆ Children's programs, and
- ◆ Evaluation of outreach for children's programs.

We paired the key words above with each other, with key words for the target population ("low-income families"), with various federal and state public insurance and comparable means-tested programs ("Medicaid," "SCHIP," "TANF," "AFDC," "WIC," "food stamps," "National School Lunch Program," "EPSDT," "SSI," "Head Start," and "school-based health clinics"), with words associated with public and private health promotion and prevention campaigns (e.g., "immunizations" and "marketing") and with "Medicare." For example, we searched MEDLINE using the key words "Evaluation" and "Medicaid" together, as well as "Outreach" and "EPSDT" together. Not all possible combinations were explored; however, more than 161 separate searches were completed, generating 13,156 titles or abstracts of articles.²⁹ Appendix B provides a listing of the number of citations identified through each set of key word searches for each of the electronic databases searched.³⁰

Step 2: Journals. Eight additional journals not included in the electronic databases but potentially having articles of relevance to the literature review were hand-searched.³¹ These journals were:

²⁸ The HSRProj database was primarily used to obtain information on evaluation research in progress. The HSRProj database includes grant information for the Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, Department of Agriculture, Department of Commerce, Department of Defense, Department of Health and Human Services, Department of Veterans Affairs, Food and Drug Administration, Health Care Financing Administration, Health Resources and Services Administration, Indian Health Services, Medicare Payment Advisory Commission, National Institutes of Health, National Science Foundation, Substance Abuse and Mental Health Services Administration, Bureau of Elder and Adult Services, Bureau of Medical Services, Mental Retardation and Substance Abuse Services of the Maine Department of Human Services, Archstone Foundation, Colorado Trust, The Commonwealth Fund, William T. Grant Foundation, John A. Hartford Foundation, The Henry J. Kaiser Family Foundation, WK Kellogg Foundation, John D & Catherine T. MacArthur Foundation, David and Lucile Packard Foundation, Pew Charitable Trusts, United Hospital Fund, Robert Wood Johnson Foundation, Aetna, Harvard Pilgrim Health Care, National Multiple Sclerosis Society, New Zealand Health Funding Agency, American Association of Retired Persons, Prudential Center for Health Care Research, United Health Care Center for Health Care Policy and Evaluation, and University of North Carolina Hospitals.

²⁹ No time constraints were placed on publication dates of articles in these searches. Nor were the articles identified through these searches unique to a particular database or set of key words although the amount of overlap was not documented.

³⁰ Because the HSRProj database was primarily used to obtain information on evaluation research in progress rather than to locate published studies, key search words and phrases are not shown for this database in Appendix B. However, similar searches were performed using HSRProj.

³¹ The same key words in titles and abstracts were used as criteria but only the 1999 issues of the listed journals were hand-searched.

- ◆ *The American Journal of Evaluation* (formerly *Process Evaluation*),
- ◆ *Evaluation and Program Planning*,
- ◆ *Evaluation Review: A Journal of Applied Social Research*,
- ◆ *Journal of Health Communication*,
- ◆ *New Direction for Evaluation*,
- ◆ *Promotion and Education*,
- ◆ *Qualitative Health Review*, and
- ◆ *Journal of School Health*.

Step 3: Internet. The same sets of key words listed above were used in our Internet searches. Internet searches were performed primarily to locate research in progress and unpublished government-sponsored evaluation reports. We used several search engines (e.g., Yahoo, Lycos) to search government websites (e.g., U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, U.S. Department of Agriculture (USDA)); advocacy websites (e.g., Children's Defense Fund, Families USA, National Association of Child Advocates); and associations, foundations, organizations, and health services research websites (e.g., National Governors Association, Kaiser Family Foundation, Flinn Foundation, and the Commonwealth Fund). Appendix C provides a complete listing of the search engines and websites searched. Internet searches were used to identify relevant unpublished evaluation studies and to supplement the electronic database searches where we did not have the anticipated number of hits (e.g., we searched for Food Stamp outreach evaluations on the USDA website because we did not get many hits in the electronic database searches).

Step 4: Other Sources. To help ensure that we had identified all relevant published and unpublished evaluations of outreach interventions and evaluations in progress, we also contacted experts in several fields, contacted state SCHIP directors and staff from various state public assistance agencies, and relied on our in-house collection of outreach-related reports obtained for our previous research on SCHIP and Medicaid outreach.

- ◆ Organizations and experts. We reviewed reference lists from published and unpublished studies to identify further possible candidates, and consulted with many experts in social marketing, public relations, public health, children's advocacy, and marketing and health services research.
- ◆ In-house documents. We used our in-house collection of outreach-related reports on public assistance programs, particularly on Medicaid, SCHIP, and school-based outreach initiatives. All in-house documents are included in the attached bibliography.
- ◆ State CHIP directors and various State public assistance agencies. We contacted state SCHIP outreach coordinators/directors, as well as other state public assistance offices to find out what evaluations of outreach, if any, have been conducted or are being planned at the state level.³²

³² Many state employees did not return our phone calls despite multiple attempts to contact them.

Appendix D contains a complete listing of all the organizations, experts, state SCHIP directors, and various state public assistance agencies contacted by Barents for the literature review.

Literature Selection Method

Most of the electronic databases we searched display abstracts of articles identified from the search criteria, but some databases provide only a title. Project staff performed an initial review of each of the abstracts identified from the searches (or titles if only titles were available on-line) to determine whether the article appeared to meet the broad initial criteria, i.e., evaluation of an outreach intervention related to a public health insurance or means-tested public program or a public health initiative. In some cases, the full article was reviewed to assess whether it met these criteria.³³ This process resulted in 149 abstracts/articles being identified for possible inclusion in the literature synthesis from all of the sources listed above.

When abstracts/articles appeared to meet the broad criteria, they were then reviewed by senior project staff to confirm they met the criteria. The same process used for selecting articles from the electronic databases was employed to select articles from hand-searched journals.

For all of the abstracts/articles identified through initial review by senior staff, the full article was obtained and reviewed by two senior staff members to assess and concur on its research design, rigor, and relevance to the population eligible for SCHIP/Medicaid programs, as described in the next section.

Literature Review Method

Because the intent of the review is to discover the implications of methodologically-sound studies with relevance to designing outreach programs for the SCHIP- and Medicaid-eligible populations, additional criteria were required for deciding which of the articles would contribute to this objective. Based on discussions with officials at AHRQ, the following five criteria were adopted for deciding which articles should be included in the evidence tables from among the articles identified in the literature search:

- ◆ The study's outreach topic must be a public health insurance or comparable means-tested program (e.g., Food Stamps, WIC),
- ◆ The program should be targeted at families and/or children,
- ◆ The study must include a specific outreach intervention(s) whose effectiveness was evaluated in an empirical setting,
- ◆ The study should either have been published in a peer-reviewed journal or sponsored by a federal or state agency, and
- ◆ The study's methodology should demonstrate/discuss a level of certainty in the results appropriate to the research design.

As is evident from the bibliography, most of the outreach intervention evaluations published in peer-reviewed journals are in the public health area rather than the public insurance area. The

³³ If only the title was available through the electronic database, the full article was obtained and reviewed.

first criterion formalized our decision to limit the scope of the literature review to public health insurance or means-tested public programs. The decision to restrict the review to evaluations of outreach interventions to increase awareness or enrollment in these programs was based on the volume and diversity of the public health research and its questionable applicability to public insurance outreach. We faced a large variety of topic areas and subject populations and an absence of research to guide decisions on where to draw the line with respect to relevance to outreach for public insurance.³⁴ Additionally, a narrower focus was more feasible given the time and resource constraints of the study.

The second criterion focused our review on outreach to families and children. The social marketing literature emphasizes the importance of knowing the behavioral, socio-economic, and demographic characteristics of your target audience.³⁵ For example, the elderly Medicare population and families with children are very different audiences from a social marketing perspective, and results of effective outreach to the elderly are therefore less likely to provide credible lessons for outreach to families with children.

Much of the recent research done on SCHIP and Medicaid outreach has been formative, rather than evaluative, in nature. As summarized in the introduction, a number of studies have convened focus groups and conducted structured interviews and technical expert panels to identify barriers to enrollment and potentially effective messages and media for reaching the targeted populations. The third criterion is intended to exclude these formative studies, important as they are in identifying hypotheses to be tested by outreach programs, and focus the analysis on studies that have actually implemented an outreach activity or set of activities.

The fourth criterion – inclusion in a peer-reviewed journal and/or sponsored by a federal or state agency – was adopted as an initial screening proxy for methodological rigor³⁶ and potential

³⁴ Three areas of concern contributed to this decision: (1) The public health literature on outreach covers a wide range of health initiatives (e.g., “drink milk,” smoking cessation, “eat more fruits and vegetables,” HIV and AIDS risk reduction, anti-drug, and bicycle helmet campaigns), health services (e.g., well-child health screenings, drug abuse counseling, pre-natal and post-natal services, pediatric asthma care, mental health care, child diabetes education, and child and adult immunizations), and outreach interventions (e.g., home visits, in-school and in-home education programs, counseling services, mass media campaigns, visit and immunization schedule reminders). Funding for this project, however, prohibited our conducting a literature review of all of these diverse areas. (2) Some of the public health outreach evaluations that we reviewed preliminarily had inconsistent results. For example, there is a very large public health literature evaluating the effectiveness of home visits on changing behaviors or motivating use of specific health services. However, the results of these studies suggest that home visits are sometimes effective and sometimes have no significant effects. Including these studies would not have provided clear direction on whether home visits are an effective outreach method for SCHIP or Medicaid. (3) It is not clear whether interventions that are effective for increasing use of a public health service are as likely to be effective in increasing enrollment in a public insurance program. Use of a health service may be a less complicated process than the process of obtaining and completing an application for insurance and providing required documentation. The benefits from a health service may also be more immediate and obvious than health insurance benefits.

³⁵ Sutton, 1999; Summer, Brecht Carpenter, and Kavanagh, 1999; National Cancer Institute, 1997; Centers for Disease Control and Prevention, 1998; Kline Weinrich, 1997.

³⁶ While all evaluations should strive for methodological rigor, the particular situation should dictate the kind of evaluation that is feasible given the questions asked, the resources available, and the training in research methodology of the evaluation team. “A consensus has gradually emerged that the important challenge is to match methods appropriately to empirical questions and issues, and not to universally advocate any single methods approach for all problems” (Patton, 1999).

importance to outreach design decisions. The articles reviewed include quantitative, qualitative, descriptive, and mixed-methods research designs. They vary a great deal in the degree to which the evaluation methodology has been described.

The last criterion highlights the importance of credible findings; for each research design described below, practitioners have developed and are constantly refining methods and standards for establishing the reliability of their approach and of their findings. The credibility of this literature synthesis rests in turn on the credibility of the articles reviewed.

Classification of Research Designs Included in the Evidence Tables

The evaluations of public health insurance and comparable means-tested programs reviewed for this report used a variety of methodologies including case studies, multivariate and time series regressions, and descriptive statistics. There were no studies that used experimental designs, e.g., random control trials, or observed control trials meeting the five criteria above. The classification groupings below identify the type of research designs included in the evidence tables and the primary methods used to demonstrate the rigor or credibility of the particular methodology.³⁷

- ◆ Case study design. Reports the outcomes of an intervention on a single person or group of persons. Multiple cases may be investigated. For example, one might ask if a particular intervention has had positive results at a particular site or sites. Rigor of the case study methodology is demonstrated through an appropriate research design, clear definition of the “case,” specification of hypothesized cause-effect patterns, flexibility in responding to unanticipated discovery, investigation of rival explanations as a part of the research design, and collection of evidence from multiple sources.³⁸
- ◆ Time-series design. Predicts future movements in a variable based on past behavior of the variable and that variable alone (e.g., enrollment levels in Medicaid using quarterly or annual data). The time series may be used to demonstrate the effects on the variable’s time trend of the occurrence of a particular event or intervention which “interrupts” the sequence (e.g., introduction of presumptive eligibility or a change in state income requirements). Use of time-series models requires understanding of autocorrelation and appropriate adjustment for its impact on the estimated coefficients. The results of the time series estimation in one location could be contrasted to those found in other locations in which the intervention was not introduced to enhance the robustness of the study’s conclusions.
- ◆ Multivariate regression design. Uses least squares or maximum likelihood estimation techniques to estimate the relationship between a dependent variable (e.g., number of persons enrolled), and one or more independent variables (e.g., expenditure on outreach, implementation of presumptive eligibility, mass media effort). The reliability of the results should be demonstrated with tests for the statistical significance of the independent variables’ estimated coefficients, e.g., t-tests. The “goodness of fit” or explained variation in the dependent variable can be indicated by the R^2 . The statistical significance of the R^2 statistic should also be indicated.

³⁷ The classifications shown above are based on Yeaton and Camberg, 1997; Pindyck and Rubinfeld, 1981.

³⁸ The characterization of rigor in case studies is drawn from Yin, 1999.

- ◆ Descriptive statistics (with statistical tests for significance). Reports the frequency, range and mean values of a particular variable or variables. The values can be computed before and after the occurrence of an intervention. The results of statistical tests are also reported to support the statistical significance of changes in, for example, the mean value of the variables before and after the intervention. Significance depends upon both the magnitude of the difference in values and the number of observations (size of the sample).
- ◆ Descriptive statistics (without statistical tests for significance). Reports the frequency, range and mean values of a particular variable or variables, but no statistical tests are conducted. The values can be computed before and after the occurrence of an event. Statistical tests will not be applicable if the entire population under consideration (no sampling) is used to calculate the statistic.

The type of research design is identified for each cited study in the evidence tables. From the set of reviewed articles, nine articles met our full inclusion criteria and were included in our sample for detailed review.

Screening criteria for research in progress were the same as screening criteria for the completed research in all but three respects:

- ◆ The ongoing research by definition could not yet have been published in a peer-reviewed journal or released publicly by the state or federal-sponsoring agency.
- ◆ The credibility of the research findings based on methodology and presentation of results could not be documented for ongoing research.
- ◆ The scope of potential research was limited to research on SCHIP/Medicaid outreach interventions; ongoing evaluations of other means-tested programs were not searched for.

Using these criteria, we identified 17 evaluations of outreach interventions to increase Medicaid/SCHIP enrollment that are underway. A description of the research in progress is provided in the “partial evidence” table (Table 6) in Appendix E.

FINDINGS

This section first provides an overview of the nine outreach steps addressed by the completed evaluation studies that we reviewed and by the 17 evaluations currently in progress, based on Table 1 in Appendix A. The section then summarizes findings from the nine completed evaluations we reviewed, with details of the evaluations provided in Tables 2 through 5 beginning on page 19. Finally, the section briefly describes research in progress concerning evaluations of outreach interventions to increase awareness of, and enrollment in, Medicaid and SCHIP programs, with more detailed information presented in Table 6 in Appendix E.

Outreach Steps

As shown in Table 1 in Appendix A, most of the completed evaluation studies we reviewed do not limit their research to one outreach step. However, the majority of outreach interventions that were evaluated either address systemic barriers to enrollment or changes in state programs (with or without addressing other outreach steps), or were designed to address the entire range of outreach steps from identification of potentially eligible individuals through direct application assistance, tracking, and follow-up.

Four of the nine completed studies examine the impact of changes in systemic or program barriers to enrollment for Medicaid or SCHIP programs (e.g., adoption of presumptive or expedited eligibility, or simplification of the application process). Of the evaluations in progress, several will examine how public insurance expansions and changes in program systems impact enrollment in these programs (e.g., the four HCFA-funded Mathematica studies and the Urban Institute study funded by The Robert Wood Johnson Foundation) although these studies have not yet determined the specific outreach activities to be included in the evaluations.

Two of the nine completed studies only mention state outreach activities to publicize expansions or changes in the state's Medicaid program (e.g., through large-scale publicity campaigns, telephone hotlines, and other notification efforts such as brochures, posters, and direct mailings) but, as discussed below, they do not link these efforts to increased awareness or enrollment outcomes. In contrast, two other completed studies directly examine the effectiveness of interventions to increase program awareness. Grant and colleague's (1999) research focuses on activities to improve awareness of California's new SCHIP program among a Chinese community; the study presents descriptive statistics of their findings about which activity appears to have increased program awareness the most. Stine's research (1991) indirectly examines interventions to increase public awareness of the Medicaid program by assuming that the more a county spends or enrolls people in social services programs, the more likely they are to hear about other programs that might benefit them, including Medicaid.

Several of the research projects currently underway will use consumer surveys to assess the relative success of different state outreach activities to raise awareness of Medicaid and SCHIP programs (although specific state activities have not yet been determined). In addition, Shenkman's study will examine the effectiveness of two state activities to increase awareness and understanding of Florida's SCHIP program for women in the state's Welfare-to-Work program who have recently lost Medicaid eligibility for their children. These outreach

interventions involve direct mailings and door-to-door outreach (which will also include application assistance).

Two of the nine completed studies we reviewed examine the effectiveness of what we call “case management/advocacy” interventions. This term captures attempts to improve enrollment in public insurance programs by contracting with organizations (usually local community-based organizations or coalitions) to address the entire range of outreach steps from identification of potentially eligible individuals to facilitating enrollment through direct application assistance, tracking, and follow-up. This is by far the most frequent type of evaluation research in progress of efforts to increase enrollment in Medicaid and SCHIP programs, with 7 of the 17 studies underway that we identified evaluating the effectiveness of management/advocacy interventions.

One of the completed studies we reviewed (Rosenbach, et al., 1997) is unique in that it attempted to assess whether a strategy to overcome the welfare stigma barrier associated with public welfare programs such as Medicaid – by positioning Medicaid-expansion programs as “private-like” insurance instead of “Medicaid-like” insurance – affected the reasons people gave for enrolling in the programs. As discussed in the introduction, this idea has been suggested to reduce the welfare stigma attached to Medicaid and SCHIP enrollment. The Urban Institute evaluation in progress, funded by the Robert Wood Johnson Foundation, will also assess whether state efforts to address the welfare stigma affects enrollment.

Completed Evaluations

Tables 2 through 5, beginning on page 19, summarize the nine studies that met the criteria for detailed review. Most of the reviewed evaluations do not evaluate a single outreach intervention. Instead, a number of interventions are described and/or measured and the group of interventions is then associated with an outcome. This makes it difficult to conclude that a particular intervention was or was not effective or that one intervention was more effective than another. The reviewed studies also employ a wide variety of study designs. The variation in the subject matter and approaches of the studies makes only a descriptive summary of the findings feasible.

Case Management/Advocacy Intervention to Increase Public Insurance Program Enrollment

Two of the studies we reviewed address outreach steps 1 through 6 by evaluating case-management/advocacy approaches to increasing enrollment (see Table 2 beginning on page 19). Based on the number of studies currently in progress to evaluate the ability of community-based case management/advocacy models to increase Medicaid and SCHIP enrollment (see Table 6 in Appendix E), the findings from the two completed studies should prove very useful for designing and implementing future case management/advocacy models. However, because the model is fundamentally an approach that addresses all outreach steps from identification of potential eligibles to direct application assistance and follow-up, it comprises a large and diverse set of outreach activities. The types of interventions employed depend on how an organization implements the model. In turn, this makes it extremely difficult to evaluate the effectiveness of a case management/advocacy model as a single “intervention.”

- ◆ LTG Associates’ (1999) study demonstrates that there are very many dimensions to what makes an individual outreach activity more or less successful within a case management model framework; findings from the study are too numerous to summarize here. However,

this type of study can be used as a roadmap for pointing out weaknesses in, or strengthening, a set of activities included in a future case management project to increase enrollment in public insurance programs.

- ◆ Bradley and Martin (1994) found that the proportion of case management participants enrolled in prenatal care programs, WIC, Medicaid, and Food Stamps increased significantly following admission to the case management program. They also found that enrollment in the means-tested programs tended to occur very soon (one month) after admission to case management. However, the study does not assess which case management activities had more or less impact on enrollment and why. This lack of detail makes the study less useful than LTG Associates' research for drawing lessons to increase the effectiveness of future case management/advocacy interventions.

Table 2. Evidence Table of Two Completed Evaluation Studies

	LTG Associates, Inc. (July 1999), <u>Food Stamp Program Client Enrollment Assistance Demonstration Projects: Final Evaluation Report</u> , prepared for the U.S. Department of Agriculture, Food and Nutrition Service
Research Objective	<p>Assess the effectiveness of demonstration project grants to local, mainly non-profit social-service organizations to develop and implement innovative client-assistance strategies to help eligible members of under-served, hard-to-reach population groups gain access to the Food Stamp Program (FSP). Three basic questions guided the evaluation:</p> <ul style="list-style-type: none"> ♦ What barriers do eligible clients encounter in gaining access to the FSP? ♦ What methods of outreach and client assistance are most effective in helping eligible persons overcome these barriers? ♦ Can public-private collaboration between project sponsors and local food stamp offices facilitate eligible persons' completion of the enrollment process?
Study Timeframe	1993 – 1996
Study Population	Target groups included low-income populations encompassing working people and families; older people; people with disabilities; homeless people; members of non-English-speaking populations; and members of other minority populations including African Americans, Hispanic Americans, Native Americans, Asian Americans and Pacific Islanders. The targeted population for the outreach intervention depended on the demonstration site (26 demonstration sites were included in the study).
Intervention(s)	<p>Case management/advocacy:</p> <ul style="list-style-type: none"> ♦ 26 local social-service organizations funded to identify potentially eligible children, increase awareness of the Food Stamp Program, and facilitate enrollment in the program. ♦ Grantees employed a variety of activities: establish public/private collaboration (partnering); client identification activities (door-to-door canvassing; partnering for client lists and contacts; screening clients who came to the agency for other types of assistance; outreach workers visiting other offices, sites or events which their target population or the general public frequents); public information and education services (mass media – radio, TV, newspapers; PSAs; flyers, fact sheets, posters, and brochures; newspaper and newsletter articles; toll-free telephone lines; small group presentations); alternative sites/methods/times for applying (alternative sites, flexible office hours, accepted applications from grantee staff on behalf of clients); a wide range of application assistance services and follow-up and advocacy services (one-on-one assistance). Only a few projects conducted all of these activities. Projects offered services based on their project design, the needs of their clients, the skill level of staff, and the number of staff and other resources available to them.
Method(s)	<p>Case study design:</p> <ul style="list-style-type: none"> ♦ Case study approach to evaluate 26 demonstration projects that developed and implemented innovative client- assistance strategies to help eligible members of under-served, hard-to-reach population groups gain access to the Food Stamp Program (FSP). ♦ Quantitative data collected included client contacts and client referrals from project staff, and client applications and client enrollments from the local food stamp office. ♦ Qualitative information was collected from review of project reports and other written materials; monthly telephone interviews with project managers; and in-person, on-site observations and discussions with project staff, eligibility workers, clients, and FSP-

**Table 2. Evidence Table of Two Completed Evaluation Studies
Case Management/Advocacy Intervention (Outreach Steps 1 through 6)**

	<p>eligible nonparticipants. Information was collected mainly through open-ended questions contained in interviewing guides, and explored factors that appeared to influence FSP participation or non-participation, contextual issues facing the projects and events or situations in the communities that might influence project outcomes, and contextual data about each community's social and economic conditions, other food resources available, transportation, demographic patterns, the location of both grantee agencies and food stamp offices, and places to cash vouchers and to use food stamps in relation to the location of the target population.</p> <ul style="list-style-type: none"> ◆ Evaluation consisted of monthly analysis of interim data, interim syntheses of data and development of new questions, and a final synthesis and analysis of data. The ongoing process used to analyze the data was based on principles of grounded theory research found in Crabtree and Miller (1992), Denzin and Lincoln (1994), and Silverman (1993). A lexical computer program (ISYS) was used to review the majority of printed project documentation to allow evaluators to determine associations between concepts and to point out any specific interrelationships they may have missed.
Outcome(s) Measured	<ul style="list-style-type: none"> ◆ Number of potentially eligible people contacted either one-on-one or in a group setting, ◆ Number of inquiries based on public information activities, ◆ Number of people referred by project staff to the Food Stamp Program, ◆ Number of people who applied for food stamps, ◆ Number of people enrolled in the Food Stamp Program.
Findings*	<ul style="list-style-type: none"> ◆ Public/private collaboration between the demonstration site organization and local FSP office staff proved useful in overcoming many of the barriers experienced by clients in seeking to enroll in the FSP. ◆ Contacting potentially eligible clients in settings where some degree of comfort, safety, and privacy were available and where clients' circumstances allowed time to talk proved effective. ◆ Sites where potentially eligible persons already were seeking food or other aid were particularly successful for identifying eligible persons and referring them to application assistance sites; door-to-door outreach as practiced by staff in these demonstration projects was not a productive method for contacting interested and potentially eligible people. ◆ Outreach workers who were experienced with the target population, sensitive in personal interactions, and well-trained in FSP procedures made a substantial difference. ◆ The success of media efforts to inform potentially eligible persons about the FSP were difficult to assess; language-specific messages on TV or radio stations targeting specific ethnic populations showed some success; localized media appeared to be most effective. ◆ The use of 1-800 phone number for individuals to request detailed information on FSP appeared effective. ◆ Direct assistance in the application process was most effective when good liaison was maintained between grantee and FSP staffs, with clearly identified contact persons within the food stamp office. ◆ Flexibility of several FSP office procedure was effective (alternative application sites, flexible office hours, accepting applications from grantee staff on behalf of clients). People who were eligible for expedited service tended to enroll in the FSP more often than those who were not, primarily because it reduced enrollment barriers.

**Table 2. Evidence Table of Two Completed Evaluation Studies
Case Management/Advocacy Intervention (Outreach Steps 1 through 6)**

	<ul style="list-style-type: none"> ◆ For clients who needed services that required application assistance, client pre-screening for eligibility by the FSP office or the non-profit grantee staff for potential FSP eligibility was a very good way to motivate eligible people to apply. It decreased client apprehension about applying for FSP and informed them of FSP benefits, and increased application acceptance. ◆ Projects demonstrated that motivated and well-prepared non-profit agencies, especially those that included a strong public/private partnership, can provide highly individualized, supportive services enabling many eligible persons in hard-to-reach population groups to successfully complete FSP enrollment.
Limitations and Notes	<ul style="list-style-type: none"> ◆ Much of the evaluation focused on evaluation of processes rather than evaluations of final outcomes (e.g., number of applications processed, number enrolled in the Food Stamp Program, etc.). ◆ Effectiveness of interventions was not differentiated among the different target population groups included in the demonstration. ◆ Little detail was provided about the effectiveness of targeting interventions to different populations or tailoring interventions to different population characteristics and needs. ◆ In most cases, interventions in a specific demonstration site were not tied to outcomes in that site; outcomes varied tremendously across sites.

* Within each of these broad findings are a large number of specific findings that made each intervention more or less effective. For more details on these findings, see the full FSP report.

Table 2. Evidence Table of Two Completed Evaluation Studies Case Management/Advocacy Intervention (Outreach Steps 1 through 6)	
Study Citation	Bradley, Patricia J., and Joanne Martin (December 1994), "The Impact of Home Visits on Enrollment Patterns in Pregnancy-Related Services Among Low-Income Women," <u>Public Health Nursing</u> , 11(6): 392-8
Research Objective	Assess the effectiveness of home visits (i.e., case management services) on enrollment in pregnancy-related programs
Study Timeframe	July 1, 1990 to January 1, 1992; services were initiated in one study neighborhood in March 1990 and a year later in the second study neighborhood
Study Population	<p>Low-income pregnant women in two primarily African American Indianapolis urban neighborhoods with historically high black-infant mortality rates:</p> <ul style="list-style-type: none"> ♦ 93.2% of the study sample were African American, mean age was 21.7 years, 85% were single, 58% had less than a high school education, 85% lived in the families with incomes at or below the federal poverty level.
Intervention(s)	<p>Home visits by teams of workers that included registered nurses, social workers, and indigenous community health workers (i.e., case management, or care coordination, for pregnant Medicaid recipients):</p> <ul style="list-style-type: none"> ♦ The care-coordination services in this pilot project were provided by two teams, each consisting of a registered nurse, a social worker, and four indigenous community health workers. Home visits included assessment, development of a plan of care, education, social support, referral, and counseling. The community health worker scheduled home visits at least monthly; the care coordinator scheduled visits at least once each trimester and as soon as possible after the infant's birth. ♦ Referrals were obtained from clinics and other community agencies, self-referral, general out-reach, and targeted case-finding by the community health workers. ♦ A care-coordination team followed women through their pregnancies and for at least three months postpartum. <p>Participants also received telephone visits and visits at such sites as the care-coordination offices, prenatal clinics, or agencies where enrollment in the pregnancy-related services occurred. Community health workers accompanied some participants to their enrollment appointments.</p>
Method(s)	<p>Descriptive statistics with and without statistical significance tests:</p> <ul style="list-style-type: none"> ♦ Data were collected from the care-coordination records of all 381 care-coordination participants who delivered infants, or who had expected delivery dates, between July 1, 1990 and January 1, 1992. Records were maintained by the care-coordination team. The assessment form completed by the care coordinator on the first visit and the home-visit record completed by the community health worker on each of the subsequent visits were the components of the record used in the study. ♦ Each record was examined to determine if there had been an increase in enrollment in services following admission to care coordination and how soon that enrollment occurred. Data were collected on whether enrollment in the pregnancy-related services was reported at the time of admission to care coordination and prior to delivery. ♦ The McNemar test was used to determine any significant change in the proportion of participants enrolled in each of the pregnancy-related programs prior to delivery as compared with the time of admission to care coordination. The subsample used in this analysis was limited to those who had received more than one home visit and who continued to receive care until after the birth of their infants.

**Table 2. Evidence Table of Two Completed Evaluation Studies
Case Management/Advocacy Intervention (Outreach Steps 1 through 6)**

	<ul style="list-style-type: none"> ◆ Frequency of enrollments each week following admission to care coordination were examined to determine if there was a clustering of enrollment in pregnancy-related programs immediately after the first care-coordination visit. The data were analyzed by converting frequency tables to graphs. The subsample used in this analysis was limited to those not enrolled in each service at the time of admission and for whom enrollment data were available.
Outcome(s) Measured	<ul style="list-style-type: none"> ◆ Proportion of care-coordination participants enrolled in prenatal care, ◆ Proportion of care-coordination participants enrolled in the Special Supplemental Food Program for Women, Infants and Children (WIC), ◆ Proportion of care-coordination participants enrolled in Medicaid, ◆ Proportion of care-coordination participants enrolled in the Food Stamp Program.
Findings	<ul style="list-style-type: none"> ◆ The proportion of participants enrolled in prenatal care, WIC, Medicaid, and Food Stamps increased significantly following admission to care coordination: <ul style="list-style-type: none"> ◇ 85.4% of participants were enrolled in prenatal care prior to admission, compared with 99.1% of participants enrolled prior to delivery [$X^2(1, n=321) = 42.02, p<=.001$]. ◇ 60.0% of participants were enrolled in WIC prior to admission, compared with 85.8% of participants enrolled prior to delivery [$X^2(1, n=260) = 58.08, p<=.001$]. ◇ 65.8% of participants were enrolled in Medicaid prior to admission, compared with 92.2% of participants enrolled prior to delivery [$X^2(1, n=257) = 64.13, p<=.001$]. ◇ 56.6% of participants were enrolled in Food Stamps prior to admission, compared with 73.2% of participants enrolled prior to delivery [$X^2(1, n=235) = 32.09, p<=.001$]. ◆ The majority of participants who enrolled in prenatal care and WIC, after admission to care coordination, did so within one month of admission. The frequency of enrollment in Medicaid and Food Stamps was also higher in the first month of admission compared with subsequent months in the program.

**Table 2. Evidence Table of Two Completed Evaluation Studies
Case Management/Advocacy Intervention (Outreach Steps 1 through 6)**

Limitations and Notes	<ul style="list-style-type: none"> ◆ Data retrieved from the care-coordination record were based on self-reports by participants. The accuracy of the data depended upon both the willingness of participants to accurately report the status of enrollment in the pregnancy-related services and the ability of the care-coordination teams to document accurately and completely. ◆ Without an experimental design, the study cannot unequivocally determine that care-coordination services influenced the increase in program enrollments prior to delivery. However, an enrollment pattern clustered near admission (and subsequently tapering off) supports the interpretation that increased enrollment was related to the care-coordination intervention. ◆ The study could have been strengthened if participant enrollment patterns before admission to care coordination had been recorded on the assessment form. This would have made it possible to determine whether the clustering of enrollment in pregnancy-related services resulted from care-coordination interventions or simply continued an enrollment pattern surge that began before admission to care coordination. ◆ The study would also be strengthened by a more detailed description of the type of care coordination or case management services provided to participants, including the types and intensity of education, social support and counseling, and the amount of one-on-on assistance with program applications and the extent of follow-up by care coordination team members for rejected applications. ◆ The results of the study are based on a team approach, with the team made up of certain types of members. It is not clear that registered nurses, social workers, or indigenous community health workers alone could achieve the same results.
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Increasing Public Awareness and Education to Increase Public Insurance Program Enrollment

Two of the studies we reviewed deal with outreach steps 2 and 3 by examining approaches for increasing awareness and education about public health insurance programs (see Table 3 beginning on the following page). Neither, however, provides convincing evidence that the approaches evaluated are effective for these purposes – in one study the variable used as a proxy for the awareness intervention is problematic, and in the other, findings are based on descriptive statistics from responses to an informal, non-random survey of a small number of people.

- ◆ Stine's (1991) results suggests that greater contact with social service agencies, by raising individuals' awareness of other related programs, may be an effective way to increase Medicaid enrollment for those who do not receive automatic Medicaid eligibility through enrollment in other public programs. The design and results from Stine's study, however, are difficult to interpret.
- ◆ Grant and colleagues' (1999) study suggests that using local organizations and community-based mass media to raise community awareness of SCHIP programs may be more promising than state-level efforts.

Table 3. Evidence Table of Two Completed Evaluation Studies

Study Citation	Stine, William F. (Summer 1991), "The Effect of Local Government Outreach Efforts on the Reciprocity of Selected Medicaid Programs," <i>Inquiry</i> , 28: 161-8
Research Objective	Assess whether county government expenditures on outreach improve accessibility to, and increase reciprocity of, nonmandatory Medicaid assistance for households that do not automatically qualify for benefits (e.g., through AFDC or SSI)
Study Timeframe	1988
Study Population	Persons residing in Pennsylvania's 67 counties
Intervention(s)	<ul style="list-style-type: none"> ◆ "Direct outreach" as measured by the county's expenditures on Pennsylvania's Healthy Beginnings Program* ◆ "Indirect outreach" as measured by the percentage of the county's potentially-eligible population enrolled in WIC** ◆ "Indirect outreach" as measured by the county's Department of Public Welfare expenditures on social services**
Method(s)	<p>Multivariate regression design:</p> <ul style="list-style-type: none"> ◆ Multiple regression equations were estimated where the dependent variables were the average number of monthly recipients in the two categories of medical assistance for which applicants are not required to be receiving cash assistance (Categorically Needy and Medically Needy) relative to the county's population in 1988. Explanatory variables were the same in both equations: expenditures on Healthy Beginnings per 1,000 population in 1988; percentage of the potentially-eligible population enrolled in WIC in 1988; social services expenditures per capita in 1988; the unemployment rate in 1988; percentage of population living in urbanized areas in 1980; net migration rate between 1980 and 1986; a dummy variable equal to 1 if the county is economically distressed and 0 otherwise. Sample size is 67 (each county represents an observation). ◆ Equations were estimated using the ordinary least squares (OLS) method.
Outcome(s) Measured	<ul style="list-style-type: none"> ◆ The number of Medically Needy recipients per 1,000 county population in 1988, ◆ The number of Categorically Needy recipients per 1,000 county population in 1988.
Findings	<ul style="list-style-type: none"> ◆ Expenditures on outreach efforts had a significant positive effect on recipient rates in the two Medical Assistance programs: <ul style="list-style-type: none"> ◇ For the Healthy Beginnings variable, the Medically Needy equation coefficient was .0040 (t-statistic = 3.10) and the Categorically Needy equation coefficient was .0037 (t-statistic = 2.86). ◇ For the WIC variable, the Medically Needy equation coefficient was .0516 (t-statistic = 1.39) and the Categorically Needy equation coefficient was .0672 (t-statistic = 1.95). ◇ For the social services expenditures variable, the Medically Needy equation coefficient was .0748 (t-statistic = 2.26) and the Categorically Needy equation coefficient was .0982 (t-statistic = 3.21). ◆ The results suggest greater contact with social service agencies probably is the most effective means to increase Medicaid reciprocity across the two programs. WIC outreach efforts were also found to have a greater impact than the Healthy Beginnings program, which was relatively new: <ul style="list-style-type: none"> ◇ A 1% increase in Healthy Beginnings expenditures per 1,000 population would increase Medically Needy reciprocity by 0.170% and Categorically Needy reciprocity by 0.135%. ◇ A 1% increase in WIC enrollment would increase Medically Needy reciprocity by 0.279% and Categorically Needy reciprocity

**Table 3. Evidence Table of Two Completed Evaluation Studies
Increasing Public Awareness and Education (Outreach Steps 2 and 3)**

	<p>by 0.155%.</p> <p>◇ A 1% increase in social services expenditures per capita would increase Medically Needy reciprocity by 0.410% and Categorically Needy reciprocity by 0.226%.</p>
Limitations and Notes	<ul style="list-style-type: none"> ◆ Although the regressions cannot establish definite causality between the three outreach variables and the two dependent variables, the study was strengthened by including a measure of economically-distressed counties in the equation (which had a significantly positive effect on Medically Needy and Categorically Need reciprocity). Positive correlation between the three outreach variables and the two dependent variables is to be expected because they all reflect greater need for more services. By controlling for the possible effect of social services need on reciprocity rates, the study adds more credibility to the suggestion that higher expenditures or participation in other social programs, after controlling for economic need, are linked to higher participation in Medicaid programs for households that do not automatically qualify for these benefits. ◆ Because results for the two equations did not change substantially from the OLS estimates when a three-stage least squares method was used, the OLS method was used to estimate the final equations. ◆ The sample size is small. The study would be strengthened by pooling data across several years to increase the sample size and add more reliability to the results. ◆ The study does not provide adequate explanation of why greater contact with social services agencies is expected to lead to greater enrollment in Medicaid. The study would be strengthened if the author were to provide greater detail about hypothesized or, more importantly, substantiated links between these two variables.

* In the study, “direct outreach” efforts attempt to increase enrollment by directly enlisting a targeted population into a medical assistance program. Pennsylvania’s Healthy Beginnings Program, implemented on April 1, 1988, provides Medical Assistance coverage to pregnant women and children under four in families with incomes below 100% of the poverty level. Pregnant women can receive prenatal care on a presumptive eligibility basis for a maximum of 45 days.

** In the study, “indirect outreach” efforts attempt to stimulate Medicaid enrollment by involving eligible persons in another program, under the assumption that contact with other social service programs improves the level of information individuals have and their accessibility to related programs. The more often the potentially-eligible Medicaid population interacts with other social service agencies, the greater the probability these individuals will receive Medical Assistance. WIC is an example of indirect outreach in this study. Social services funded under Pennsylvania’s Department of Public Welfare are other examples of indirect outreach in this study.

**Table 3. Evidence Table of Two Completed Evaluation Studies
Increasing Public Awareness and Education (Outreach Steps 2 and 3)**

	Grant, D., et al., (July 1999), <u>Healthy Families at Year One: Outreach, Application, and Enrollment Issues</u> , a report by the Medi-Cal Community Assistance Project, a cooperative project of Families USA, Health Access Foundation, Latino Issues Forum, and Community Health Councils, Inc. (supported by a grant from The California Wellness Foundation)
Research Objective	Assess community-based efforts in San Francisco's Chinese community to enroll uninsured children in California's new SCHIP program (Healthy Families)*
Study Timeframe	July 1998
Study Population	Low-income families in San Francisco's Chinatown
Intervention(s)	<ul style="list-style-type: none"> ◆ Chinese radio and television announcements, as part of the promotional efforts of a local community health clinic in San Francisco's Chinatown, North East Medical Services (NEMS), ◆ Other Chinatown social service providers also took part in promoting Healthy Families through referrals to NEMS, Healthy Families telemarketing, and Healthy Families workshops.
Method(s)	<p>Descriptive statistics without statistical significance tests:</p> <ul style="list-style-type: none"> ◆ 154 parents were "informally" surveyed in five sites in San Francisco's Chinatown at schools, day care providers, and social service centers; surveys were conducted orally in Cantonese. ◆ NEMS commercials had been run between four and six weeks prior to the survey.
Outcome(s) Measured	<ul style="list-style-type: none"> ◆ Enrollment in Healthy Families in San Francisco County, by race/ethnicity, ◆ Awareness of Healthy Families program, ◆ Source of knowledge about Healthy Families program.
Findings	<ul style="list-style-type: none"> ◆ In the first month of the program, 93 percent of San Francisco county's enrollees were Chinese; one year later, the county's enrollment was still almost 80 percent Chinese (Chinese are estimated to make up slightly under 40 percent of the uninsured population in San Francisco county). ◆ The informal parent surveys found that 77 percent of the respondents were aware of Healthy Families: Chinese television (32%), NEMS (16%), and Chinese radio (15%) were cited by 63 percent of the respondents as the sources of their knowledge; marketing work by the state-contracted advertising agency accounted for only 3 percent of the subjects' awareness of the program. ◆ There was a strong association of the Healthy Families program with NEMS. ◆ NEMS spent about \$10 for every Chinese child who had successfully enrolled at the time of the survey, compared with state-wide contractor spending of about \$75 per child targeted for enrollment in the first year of the program's operation.

**Table 3. Evidence Table of Two Completed Evaluation Studies
Increasing Public Awareness and Education (Outreach Steps 2 and 3)**

Limitations and Notes	<ul style="list-style-type: none"> ◆ The survey was not based on a random sample of the target population, so it is unknown how representative the findings are for the entire San Francisco Chinatown population. ◆ No statistical tests were performed on survey results to assess statistically significant differences among responses. ◆ Analysis of survey responses does not employ multivariate analysis to explore other factors or characteristics of respondents that may have contributed to the survey's findings. ◆ The enrollment figures were not linked in any way with the completed application fees paid to enrolled entities in Chinatown (a state-funded outreach activity), so the impact of this intervention on enrollment in Healthy Families among Chinatown's population is unknown. ◆ The enrollment figures were not linked specifically to NEMS's media efforts, so the specific impact of this intervention on enrollment in Healthy Families among Chinatown's population is unknown.
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*The primary purpose of the report was to describe the first year of California's experience with enrolling children in its new SCHIP program and to summarize the state's assessment of its outreach and enrollment strategy efforts, as well as the opinions of advocates working with families on a day-to-day basis. The methodology for the state's assessment was not robust enough, however, to include the findings from that portion of the report in this literature review. The report itself states that "there is little empirical evidence available to assess the effectiveness of the components of the state's outreach and enrollment strategy...." and "[i]t is difficult to evaluate the effectiveness of any one component of the outreach strategy...." The report also contained some findings from community-based outreach and enrollment efforts in Los Angeles' Koreatown and Latino enrollment in San Joaquin County. However, because the report does not provide any information as to how information was obtained or analyzed, the findings from these two community efforts are not report in the table.

Reducing Welfare Stigma to Increase Public Insurance Program Enrollment

Welfare stigma is commonly reported as a barrier to enrollment in public health insurance or comparable means-tested programs. One suggestion to address this barrier is to rename Medicaid or SCHIP programs to reduce their association with welfare or to issue “private-type” insurance cards. One study we reviewed deals with outreach step 5 to motivate people to take action to enroll in a program by examining such an intervention (see Table 4 beginning on the following page). The study provides only a small amount of indirect evidence supporting the effectiveness of such an intervention, however, because the results are based on a survey whose questions only indirectly asked about welfare stigma.

- ◆ Rosenbach and colleagues’ study (1997) provides a small amount of indirect support that positioning public insurance more as private insurance instead of public welfare may attract more people because they will view the program as providing “insurance” benefits rather than acute care, more immediate benefits.

Table 4. Evidence Table of One Completed Evaluation Study

	Rosenbach, M. L., et al., (December 1997), <u>Evaluation of the Medicaid Demonstration: Revised Final Report</u> , prepared by Health Economics Research, Inc., Research Triangle Institute, and the University of Washington, for the Health Care Financing Administration
Research Objective	Assess the performance of three state demonstrations that allowed states to extend Medicaid coverage to certain low-income families not otherwise qualified to receive Medicaid benefits with respect to enrollment, costs and utilization, and access and satisfaction*
Study Timeframe	December 1992 – December 1996
Study Population	Individuals not receiving Medicaid with family incomes below 150 percent of the federal poverty level: Maine and Washington used an individual enrollment model (Maine targeted individuals state-wide; Washington targeted individuals in Spokane County); South Carolina had a group enrollment model, targeting small businesses (3-100 employees) in two counties
Intervention(s)	Positioning a program more like “private insurance” instead of “welfare” (in general, however, there was a lack of marketing of the programs and little formal outreach): <ul style="list-style-type: none"> ◆ ME’s program built upon the existing Medicaid infrastructure and was viewed simply as another category of Medicaid eligibility, ◆ SC’s and WA’s programs pursued innovative efforts to privatize or decentralize Medicaid-like coverage, by positioning the coverage as “insurance” rather than simply “claims payment.” Both programs deliberately avoided a direction association with Medicaid.
Method(s)	Mixed methods: <ul style="list-style-type: none"> ◆ Case study design: Assessed the implementation of each demonstration through on-site interviews and review of program documents. Interviews were conducted with state officials, the managed care organizations in WA, employers and insurance brokers in SC, local physicians or their office staff, local public health officials, social service agencies, and advocacy organizations. ◆ Descriptive statistics with statistical significance tests: <ul style="list-style-type: none"> ◇ T-tests of proportions were conducted to assess statistically significant differences in survey answers among the three states. ◇ Data collection: Primary data collection component involved collecting survey data on insurance status, utilization, health status, access to care, and satisfaction with care for a sample of demonstration participants and selected comparison groups. The researchers relied on one to two rounds of survey data collection following implementation of demonstration, including samples of demonstration participants and a comparison group where possible (sample sizes: ME - 440 demonstration participants, 213 comparison group (time 1); 321 demonstration participants, 152 comparison group (time 2); SC - 123 employers and 400 employees participating in demonstration, 104 employers and 30 employees in comparison group (time 1); 243 participating employees (time 2); WA - 202 demonstration participants (time 1). Administrative data component relied on eligibility, enrollment claims, and encounter data maintained by each state, to provide information on enrollment trends and cost and utilization patterns of demonstration participants, traditional Medicaid beneficiaries, and other enrollees in state-sponsored health insurance programs for low-income populations.
Outcome(s) Measured	<ul style="list-style-type: none"> ◆ Actual enrollment compared with enrollment targets, ◆ Reasons enrollees cited for joining program.

**Table 4. Evidence Table of One Completed Evaluation Study
Reducing Welfare Stigma (Outreach Step 5)**

Findings	<ul style="list-style-type: none"> ◆ Simply offering a program to low-income uninsured individuals, families, or employees does not ensure they will know about the program or choose to participate. Even "free" programs need to be advertised. In addition, program volatility negatively affects states' willingness to market the program and individuals' willingness to join the program. None of the three programs easily achieved their enrollment targets: <ul style="list-style-type: none"> ◇ ME's projected enrollment target for new enrollees was 4,000; open enrollment yielded only 800 new eligibles, with the remainder identified through a review of Medicaid denials. ◇ SC projected an average monthly enrollment of 1,300 members, with a first-year maximum of 1,390 at any one time; membership peaked at 1,211 in October 1995 – about 30 months into the program. ◇ WA projected enrollment of 4,200, but after the first year, only 35 percent of this goal had been reached. ◆ Each program's orientation and implementation directly influenced the risk profile: <ul style="list-style-type: none"> ◇ Enrollees in ME were far more likely to join the program because of a "current medical condition," reflecting the role of the ME medical community (especially hospitals) in referring their patients to the program. Like Medicaid, enrollees perceived the program as a way to pay medical bills when they were sick. The program was not marketed as an insurance product and enrollees did not seem to understand they could not re-enroll at will. <ul style="list-style-type: none"> ➤ Percent answering "current medical condition": ME (38.6%), SC (6.7%), WA (18.9%) - ME significantly different from SC and WA, and SC significantly different from WA, at 5% level. ◇ SC's enrollees, on the other hand, were most likely to join the program to "protect against a possible future accident or illness," reflecting the insurance orientation of the program. As an employment-based program, enrollees were in better health than those enrolled in the other two programs. <ul style="list-style-type: none"> ➤ Percent answering "protect against a possible future accident or illness": ME (36.4%), SC (52.8%), WA (44.9%) – ME significantly different from SC and WA, and SC significantly different from WA, at 5% level. ◇ WA's enrollees tended to report they joined to protect against future health care needs, as well as to afford routine checkups, consistent with the managed care orientation of the program. <ul style="list-style-type: none"> ➤ Percent answering "routine checkup": ME (25.0%), SC (16.6%), WA (36.2%) – ME significantly different from SC and WA, and SC significantly different from WA, at 5% level.
Limitations and Notes	<ul style="list-style-type: none"> ◆ Analysis of survey responses does not employ multivariate analysis to explore other factors or characteristics of respondents that may have contributed to the differences in responses by state program in addition to, or instead of, program orientation.

*The key research question of relevance for this literature review is "Who enrolled in the demonstration program and why?". Only outcomes measured and findings relevant for the literature review are included in the table.

Simplified Application Procedures and Changes in Program Characteristics to Increase Public Insurance Program Enrollment

Four of the completed studies we reviewed deal with outreach steps 7 and 8 to address systemic barriers to enrollment by examining the impact on Medicaid enrollment of simplified application procedures and/or presumptive eligibility (see Table 5 beginning on the following page). The four studies provide only slight evidence that simplification of application procedures or presumptive eligibility will increase enrollment.

- ◆ Mayer's (1992) study design and analyses did not permit him to show that the statistically significant increases he found in Medicaid-financed deliveries in the two states resulted from the adoption of presumptive eligibility or other proactive outreach activities conducted by the states.
- ◆ Dubay and colleagues (1995) found that the average waiting period for Medicaid coverage for prenatal care appeared to be considerably shortened because of changes in the application process for pregnant women. However, the results were not uniform within or across the sites. They also found that California's out-stationing program appears to have successfully hastened the eligibility process for women receiving care in clinics (the study does not report findings for the other three states). Although not perfectly consistent, these findings provide some support to the proposition that simplified application procedures can increase low-income pregnant women's timely access to prenatal care.
- ◆ Piper and colleagues' study (1994) establishes fairly conclusively that – at least in Tennessee and for the period and populations studied (White and African low-income pregnant women) – the adoption of presumptive eligibility shortened the time from initial Medicaid application to enrollment or receipt of prenatal care. While their results are not necessarily representative of all states, they provide evidence that adoption of presumptive eligibility can increase access to health care services in the short-term.
- ◆ Bono and colleague's (1999) study suggests that people were *less* satisfied with the adoption of a seemingly easier Medicaid application and eligibility process compared with the former, ostensibly more burdensome process.

Study Citation	Mayer, Jeffrey (1992), "A Time Series Study of the Impact of Eligibility Expansion on Medicaid Financing of Births," <u>Journal of Health & Social Policy</u> , 4(2): 1-17
Research Objective	Assess whether eligibility expansions for Medicaid financing of deliveries, combined with aggressive outreach, led to a significant increase in Medicaid-financed deliveries
Study Timeframe	July 1986-June 1989 (Florida); January 1986-June 1989 (Oregon)
Study Population	Women eligible for Medicaid financing of births in Florida and Oregon during the study period
Intervention(s)	<ul style="list-style-type: none"> ◆ Simplified application procedures (presumptive or expedited eligibility; dropped assets testing; continuous eligibility; one-page application; out-stationed Medicaid eligibility workers (FL only); concurrent with expanded Medicaid eligibility for low-income pregnant women), ◆ Instituted maternity telephone hot-line (FL only), ◆ PSAs on radio and TV to advertise expansion, ◆ Case-finding by outreach workers, ◆ Other notification efforts (brochures, posters, mailings to human service clients and Medicaid providers).
Method(s)	<p>Time series design:</p> <ul style="list-style-type: none"> ◆ ARIMA interrupted time series methods. Used time series data of monthly totals of Medicaid-financed births in the two states before and after implementation of the expansion policy, abstracted from 1986-1989 Medicaid hospital claims files. Sample size is not reported in the study. ◇ Data collection. Information on policy implementation, eligibility reforms, and outreach efforts collected through interviews with state and local program managers and staff, direct observation of program processes, and review of program documents and archives.
Outcome(s) Measured	Number of Medicaid-financed deliveries
Findings	<ul style="list-style-type: none"> ◆ Medicaid-financed deliveries in two states (FL and OR) that expanded eligibility, simplified application procedures, and publicized the expansions, increased significantly after expansion compared to the pre-expansion period. ◆ In both states, the t-ratios for the level and rate parameters indicate a statistically significant policy effect. ◆ In Florida, the post-expansion level represents a monthly net gain of 1,771 births over the pre-expansion level. In Oregon, the post-expansion level represents a monthly net gain of 327 births over the pre-expansion level.

Table 5. Evidence Table of Four Completed Evaluation Studies

Simplified Application Procedures and Changes in Program Characteristics (Outreach Steps 7 and 8)

Limitations and Notes	<ul style="list-style-type: none"> ◆ The study does not compare the outcomes from expanded eligibility and other outreach efforts with outcomes in the other states that only expanded eligibility. For the purposes of this literature review, his study would have been strengthened by comparing changes in pre- and post-Medicaid-financed births in the two states with changes in Medicaid-financed births in the other eight states that also adopted expanded eligibility but may not have adopted presumptive eligibility, made efforts to simplify application procedures, and publicized the expansions. ◆ Because the study uses time series methodology, it does not assess the individual impacts of each of the intervention activities separately - “intervention” was measured as a dummy variable, coded as a 0 before the expansion and 1 after the expansion. The study, therefore, does not establish whether expanded Medicaid eligibility, the simplification of application procedures, or the publicity and other outreach efforts alone would have caused the results. ◆ Although the study took three approaches to rule out history as an alternative explanation to the results, historical trends (other confounding factors) could still affect the results.* ◆ The two states included in the study were chosen due to data availability – data management ability could be correlated with quality of programs, biasing the study sample. ◆ No sample size is provided in the study, making it difficult to interpret the statistical results. ◆ The two study states were proactive and aggressive in their outreach efforts to attract pregnant women into prenatal care and expansion programs. However, specific details about the publicity campaigns are not provided and linked to outcomes.
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*1) To control for the increase in Medicaid births due to increases in fertility or growth in the size of the population of women of child-bearing age, the percent of total state births for each month that were financed by Medicaid were computed; ARIMA analysis was then replicated with the “percent of all births” series using the same 42 and 36 month intervals; 2) To control for increases in the relative size of high-risk mothers likely to be Medicaid eligible, changes in the proportion of births to minority, unmarried or poorly educated mothers during the pre-, during, and post-expansion years was examined; 3) During site visits, state officials were asked if there were any other events occurring near the expansion that could explain the upturn in Medicaid births.

Table 5. Evidence Table of Four Completed Evaluation Studies

Simplified Application Procedures and Changes in Program Characteristics (Outreach Steps 7 and 8)

Study Citation	Dubay, Lisa C., Genevieve M. Kenney, Stephen A. Norton, and Barbara C. Cohen (December 1995), "Local Responses to Expanded Medicaid Coverage for Pregnant Women," <i>The Milbank Quarterly</i> , 4(73): 535-63
Research Objective	Assess how the Medicaid expansions in income eligibility levels for pregnant women, implemented in four states over the period 1987-1991, affected access to prenatal care for low-income women*
Study Timeframe	April–June 1992 in Michigan, California, Georgia, and Tennessee; two local areas in each state selected for in-depth analysis
Study Population	Low-income pregnant women in the 8 local area study sites
Intervention(s)	<ul style="list-style-type: none"> ◆ Simplified application procedures: all states except CA dropped the assets test; all states adopted either expedited or presumptive eligibility (not statewide in CA); all states implemented continuous eligibility; all states out-stationed eligibility workers (not statewide in CA); all but TN shortened the application form for pregnant women. ◆ Publicity campaigns to advertise the expanded Medicaid eligibility for low-income pregnant women over the period of the study, which differed in the magnitude and timing of initiation: <ul style="list-style-type: none"> ◇ MI and CA implemented large-scale multi-media campaigns in 1990-91 to inform pregnant women about the expanded eligibility and the importance of prenatal care; in MI, outreach efforts included the advertisement of referral hotlines for pregnant women; outreach in GA involved inserting information about the expansions into utility bills and WIC mailings and expanding a hotline that offered ob/gyn referrals; in TN, a free hotline was set up in early 1992 to help women find prenatal care services, but its existence was never publicized..
Method(s)	<p>Case study design:</p> <ul style="list-style-type: none"> ◆ Case studies were conducted in the four states early in 1992. Research design followed the standard explanatory case study methodology as described by Yin (1989); it consisted of both site visits and analysis of extant data. ◆ Site visits with structured interviews: Telephone interviews were conducted with state Medicaid and Maternal and Child Health (MCH) directors and with state advocacy groups. At this time, state officials identified point persons at local health departments in potential sites. Next, in-person interviews were conducted with local health and MCH departments, health care providers, and advocacy group representatives. A snowball sampling framework was used to identify potential interviewees at the local level. A purposive sample from this set was drawn. In each site, larger providers of prenatal care to low-income women, innovative programs, and advocates who had played a major policy role at the local and/or state level were selected for interviews. Semi-structured interview guides were used to collect interview data. ◆ Extant data collection: Collection of extant data included Medicaid eligibility levels, physician fees, malpractice insurance information, methods used to finance Medicaid expansions, Medicaid-covered deliveries before the expansions (obtained from a survey of Medicaid directors by the Alan Guttmacher Institute), Medicaid-covered deliveries after expansions (obtained from state MCH and Medicaid officials), and other data.
Outcome(s) Measured	<ul style="list-style-type: none"> ◆ Percentage of Medicaid-financed births, ◆ Length of time for Medicaid enrollment processing.

**Table 5. Evidence Table of Four Completed Evaluation Studies
Simplified Application Procedures and Changes in Program Characteristics (Outreach Steps 7 and 8)**

Findings	<ul style="list-style-type: none"> ◆ There were large increases in the share of births covered by Medicaid after the eligibility expansions in all 4 states: <ul style="list-style-type: none"> ◇ CA increased from 24.3% pre-expansion to 33.0% post-expansion, ◇ GA increased from 17.4% pre-expansion to 50.0% post-expansion, ◇ MI increased from 25.0% pre-expansion to 35.0% post-expansion, ◇ TN increased from 20.3% pre-expansion to 50.0% post-expansion. ◆ Overall, average waiting period for gaining Medicaid coverage for prenatal care was considerably shortened after changes in the application process for pregnant women, but results were not uniform within or across the sites: <ul style="list-style-type: none"> ◇ The effectiveness of expedited or presumptive eligibility depended, in part, on resources and commitment; Michigan's combination of presumptive and expedited eligibility decreased waiting time for eligibility the most (to zero waiting time). ◆ Counties that took advantage of CA's out-stationing program appear to have successfully hastened the eligibility process for women receiving care in clinics (the study does not report findings for the other 3 states). ◆ The case studies yielded little evidence on the effectiveness of the states' publicity campaigns because they had not yet been evaluated.
Limitations and Notes	<ul style="list-style-type: none"> ◆ Local area sites were selected to provide a range in pre-expansion infant mortality rates and levels of urbanization across the 4 states, but are not necessarily representative of the state or of the country as a whole. ◆ Case studies cannot be used to infer causality. Therefore, interventions in the aggregate or individually could not be linked directly to the outcomes. ◆ The case studies did not account for other factors that may have changed during the period of the study that could have affected Medicaid enrollment, such as demographic changes in the target population, local outreach efforts, or other state policy changes ◆ Case study methodology inevitably involves elements of subjectivity. ◆ No information was collected from clients or from the target population.

* Additional interventions, outcome measures, and findings were included in the study to address the study's primary focus to assess whether the Medicaid expansions for pregnant women increased access to prenatal care. However, the study also examined whether these expansions, as well as application process simplification, were associated with increased enrollment of low-income pregnant women in Medicaid. Because the focus of this report is on the latter effects, only interventions, outcome measures, and findings relating to the latter topic are included in the review.

Study Citation	Piper, Joyce M., Edward F. Mitchel, Jr., and Wayne A. Ray (October 1994), "Presumptive Eligibility for Pregnant Medicaid Enrollees: Its Effects on Prenatal Care and Perinatal Outcome," <u>American Journal of Public Health</u> , 84(10): 1626-30
Research Objective	Assess the effects of presumptive eligibility for Medicaid on the receipt of prenatal care and the occurrence of low-birthweight births and neonatal, perinatal, and infant mortality*
Study Timeframe	August 1, 1988 through December 31, 1989
Study Population	<ul style="list-style-type: none"> ◆ Pregnant women who enrolled in Tennessee Medicaid in the 6-month period before presumptive eligibility was enacted (8/1/88-1/31/99; n=9495) and pregnant women who enrolled in Medicaid in the 6-month period after presumptive eligibility had been in effect for 5 months (7/1/89-12/31/89; n=9702 – 3995 of these women enrolled in Medicaid with presumptive eligibility). ◆ The study sample did not include women who were already enrolled in Medicaid before the start of their pregnancy (in effect, the study sample excluded most women who had chronic medical conditions, were very young and qualified for Medicaid as children themselves, who became pregnant during the postpartum coverage period of a previous pregnancy, or were very poor and receiving Aid to Families with Dependent Children). ◆ Study population further limited to women who were either White or African American and who had delivered a single live infant with a recorded birthweight of 500 to 6000 g or a stillborn infant.
Intervention(s)	Adoption of presumptive eligibility for low-income pregnant women**
Method(s)	<p>Descriptive statistics with statistical significance tests and multivariate regression design:</p> <ul style="list-style-type: none"> ◆ The t-test was used to test the hypothesis that presumptive eligibility shortens the time from initial Medicaid application to enrollment or receipt of prenatal care. ◆ Unconditional logistic regression models were constructed with terms that included the study period and the maternal characteristics of age group, race, marital status, educational attainment, parity density, and urban/rural county of residence. Outcome rates and adjusted odds ratios of enrollment were calculated for pregnant women who enrolled in Tennessee Medicaid in the 6-month period before presumptive eligibility was enacted and for pregnant women who enrolled in the 6-month period after presumptive eligibility had been in effect for five months. <p>Data collection:</p> <ul style="list-style-type: none"> ◆ Data were obtained from Tennessee birth, fetal death, and death certificates and Tennessee Medicaid files.
Outcome(s) Measured	Time in pregnancy that Medicaid enrollment began
Findings	<ul style="list-style-type: none"> ◆ Pregnant women who enrolled in Medicaid in the "after" time period (mean = 3.40 months, SE = 2.45) did so earlier in pregnancy than those in the "before" time period (mean = 3.59 months, SE = 2.53) (t = 5.27, P = .00002). ◆ The adjusted odds ratio indicates that women in the "after" group were 40% more likely to enroll in Medicaid in the first trimester of their pregnancy compared with women in the "before" group (adjusted odds ratio = 1.40, 95% confidence interval = 1.32, 1.48) (unadjusted enrollment rates indicate that 50.2% of women in the "after" group vs. 42.0% of women in the "before" group enrolled in Medicaid in their first trimester).

**Table 5. Evidence Table of Four Completed Evaluation Studies
Simplified Application Procedures and Changes in Program Characteristics (Outreach Steps 7 and 8)**

Limitations and Notes	<ul style="list-style-type: none"> ◆ The analysis is restricted to a single state, Tennessee. The results for Tennessee may not necessarily be representative of other states ◆ The results may be confounded by secular trends; that is, there may have been a tendency independent of the Medicaid expansion and interventions for women to obtain prenatal care earlier and more regularly over time. The pre- and post-intervention nature of their study design limited their ability to detect such a trend. ◆ The period of study was limited by changes to Tennessee’s Medicaid program on January 1, 1990. It is possible that as clients and health care providers become more familiar with presumptive eligibility, it will have an even greater effect on enrollment outcomes.
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*Although this was the primary research objective of the study, the authors also assessed the impact of presumptive eligibility on timing of enrollment in the Medicaid program. Because this report is not examining how interventions affect access to, or use of, health services, only those interventions, outcomes, and findings related to enrollment in Medicaid are presented in this review.

** Over the entire period of the study, Medicaid eligibility for pregnant women was limited to those whose countable income was at or below 100% of the FPL, and the assets test had already been dropped. The only change in the “before” and “after” periods of the study, therefore, was the facilitation of Medicaid enrollment through presumptive eligibility for low-income pregnant women.

Study Citation	Bono, Christine A., Elizabeth Shenkman, and Donna Hope-Wegener (June 1999), <u>KidCare: The Impact on Medicaid Eligibles in the Healthy Kids Program, A Six Month Follow-Up Report</u> , a report prepared for the Healthy Kids Board of Directors
Research Objective	Assess whether families enrolled in Florida's Healthy Kids Program, who were required to reapply to determine Medicaid eligibility due to Florida's SCHIP initiative (KidCare), actually became enrolled in the Medicaid program and to determine their satisfaction with the new simplified enrollment process
Study Timeframe	December 1998 - April 1999
Study Population	336 families who had at least one child enrolled in the former Healthy Kids Program and who were subsequently reviewed for transition into the Medicaid Program; children in the sample are primarily White non-Hispanic, in excellent health, and from two-parent households in which only the survey respondent works and the majority of parents have completed at least some college
Intervention(s)	<p>Simplified application form and enrollment process:</p> <ul style="list-style-type: none"> ◆ Families enrolled in the Healthy Kids Program had always been able to use a mail-in form, but still had to undergo a face-to-face interview that often lasted 90 minutes or longer; the KidCare process eliminated the face-to-face interview. ◆ A single application form was developed to establish a child's eligibility for Florida Healthy Kids, MediKids, Medicaid, or Children's Medical Services (all KidCare Program components). ◆ Families no longer have to document their income level or provide face-to-face verification – Florida's Department of Children and Families uses state computer system to verify income information. ◆ Effective January 1, 1999, children from birth to five years of age are entitled to 12 months of continuous eligibility.
Method(s)	Descriptive statistics without statistical significance tests
Outcome(s) Measured	<ul style="list-style-type: none"> ◆ Current insurance coverage, ◆ Satisfaction with the Medicaid program application process.*
Findings	<ul style="list-style-type: none"> ◆ Of children reviewed for transition into the Medicaid Program, the largest number became enrolled in Medicaid, but an almost equally large number was uninsured at the time of the interview: <ul style="list-style-type: none"> ◇ 39.6% were enrolled in the Florida Medicaid Program (the "Medicaid Group"), ◇ 31.8% were uninsured, ◇ 22.0% were enrolled in the Healthy Kids program due to ineligibility (15% never enrolled in Medicaid due to Medicaid ineligibility - the "Healthy Kids Group"; 7% re-enrolled in Healthy Kids after being told their children might be Medicaid eligible but later found out that they did not meet the Medicaid eligibility criteria), ◇ 6.5% had obtained other insurance (e.g., private insurance), ◇ For families whose children were currently enrolled in Medicaid, 85% indicated they did not choose Medicaid, but rather, were required to enter the program. ◆ A greater percentage of families reported being <i>more</i> satisfied with the original Healthy Kids application process than with the new simplified KidCare application process:

Table 5. Evidence Table of Four Completed Evaluation Studies

Simplified Application Procedures and Changes in Program Characteristics (Outreach Steps 7 and 8)

	<ul style="list-style-type: none"> ◇ Approximately 63% of the Medicaid Group reported being satisfied with the new, streamlined Medicaid application process compared with 91% who reported being satisfied with the original Healthy Kids application process, ◇ Approximately 36% of the Healthy Kids Group reported being satisfied with the new, streamlined Medicaid application process compared with 90% who reported being satisfied with the original Healthy Kids application process, ◇ Families in the Medicaid Group were generally satisfied with the new Medicaid process because it was “quick and easy” (81%). When families were dissatisfied, it was because of perceived “administrative process” problems (52.8%) or because they did not have a choice in the changeover from Healthy Kids to Medicaid (30.6%), ◇ Of families in the Medicaid and Healthy Kids Groups combined who were satisfied with the original Healthy Kids process, the majority said it was because the process with “quick and easy” (74.4%) and 17.3% said there were helpful people to assist with the application process. Of the dissatisfied families, all said it was due to “administrative process” problems. ◆ A common reason that children were uninsured was that the families had problems with the Medicaid application process or had missed a deadline.
Limitations and Notes	<ul style="list-style-type: none"> ◆ Study is based on simple, descriptive statistics with no significance tests or comparison groups. ◆ The study would be greatly strengthened by further exploration of why a much greater percentage of respondents reported satisfaction with the original Healthy Kids application process compared with the new, seemingly simplified Medicaid process. The results could be due to a variety of potential reasons: survey respondent recall of the original process, respondent confusion over whether the survey question was about the former Healthy Kids process or the new Medicaid process (Healthy Kids is still a component of the new KidCare program), or the new Medicaid process might have some elements that actually make it more complicated than the original Healthy Kids process. ◆ The study sample is fairly small, indicating that the results should be interpreted with caution.

*Additional outcomes were reported in the study but are not relevant to this literature review.

It is clear from our review of completed studies that there are large gaps in evaluations of outreach interventions to increase enrollment in public health insurance programs. Very few interventions have been evaluated, especially on an individual basis, and the completed evaluations provide scant scientific evidence about the absolute effectiveness, relative effectiveness, or cost-effectiveness of different outreach interventions to improve awareness of and enrollment in programs such as Medicaid and SCHIP. In addition, none of the studies examined the relative effectiveness of interventions for different subgroups.

Evaluations in Progress

The “partial evidence” table of research in progress (Table 6 in Appendix E) suggests that evaluations underway will fill in some of the gaps in knowledge about the success of certain interventions. The most striking pattern in the table is that the majority of current outreach evaluation research identified for this literature review focuses on community-based case management/advocacy models (7 of the 17 planned evaluations). This may be a product of the nearly complete lack of evidence about what works and does not work to increase program awareness and enrollment, especially at the community level and for different populations, in different settings, and under different circumstances. In the absence of such knowledge, turning to local community organizations to make these decisions and to facilitate enrollment may be seen as the best strategy. Although most studies have not identified cost effectiveness as an outcome to be measured, it is one of the more useful measures of effectiveness for deciding which models to replicate. The Taras study is measuring both the cost per completed application and the change in per enrollee costs as the program matures. Without comparable data from other evaluations, it will be difficult to decide which activities are likely to optimize returns from outreach activities funded.

Table 6 shows that the effectiveness of outreach activities being conducted by states will be evaluated over the next few years, with several studies assessing their effectiveness from both the states’ perspective and the consumers’ perspective. However, most of these studies have not specified which state activities, or even which states, will be included in the evaluations. Without knowing the types of outreach interventions that will be the focus of state activity evaluations or community-level case management evaluations, it is hard to say precisely which gaps in effectiveness research will be filled in the near future. The following section, therefore, identifies general gaps in our knowledge about which outreach interventions work and recommends directions for future research and research support.

GAPS IN KNOWLEDGE AND RECOMMENDATIONS

General Gaps in Knowledge about Effectiveness of Outreach Interventions

We found that rigorous evaluations of the types of outreach activities that are frequently considered to be most effective for overcoming barriers to enrollment in SCHIP, Medicaid, or other public insurance programs are largely absent from the published literature. In addition to limited research on the effectiveness of outreach activities for the “general population” of uninsured children, research is deficient with regard to outreach strategies targeting various subgroups of children, community variables that might facilitate or mitigate outreach strategies, and the cost-effectiveness of alternative approaches. Researchers Brecht Carpenter and Kavanagh have noted the same:

“Although a few individual states have evaluated the effectiveness of their outreach programs, and anecdotal evidence is plentiful concerning how well these methods work, broad based research has been very limited. Studies on outreach in other state-funded or privately-funded child health insurance programs are also quite limited. Other than analyses and evaluations of their own experiences, states have little data to rely on as they implement SCHIP. While discussions of enrollment issues and case studies of state efforts are available, in depth analyses of what works, in what circumstances, with what populations, and at what costs, was not found.”³⁹

In general, our review of the existing literature found that:

- ◆ No rigorous empirically-based evaluations exist for the large majority of interventions that have been promoted in the literature as potential tools for increasing public insurance program enrollment.
- ◆ Of the few interventions for which there are completed evaluations, we did not identify a body of literature regarding any specific intervention or set of interventions that would help us to conclude with a high degree of confidence that the results are valid. As with any scientific endeavor, multiple findings are preferred to establish credibility of the results.
- ◆ There are no completed studies that we reviewed that compare one type of intervention to another, so it is not clear which interventions might be *more* effective than others. However, several of the on-going evaluations are comparing two or more interventions.
- ◆ We did not locate any completed cost-effectiveness evaluations. This type of evaluation would help states and others to focus their attention on activities that are most likely to yield the highest returns.

Recommendations for Future Research and Research Support

Because so few interventions have been evaluated and several planned evaluations of outreach are not yet fully defined, rather than recommending evaluation of any particular outreach intervention, we suggest the following research agenda:

³⁹ Brecht Carpenter and Kavanagh, 1997.

1. **Prioritize outreach evaluation research.** Following are three suggestions for prioritizing research on the effectiveness of outreach interventions:

- a. Choose which outreach interventions to evaluate based on the top six “best practices” areas identified in the existing research Because of the dearth of rigorous evaluation studies, state planning of SCHIP and Medicaid outreach activities is often based on shared experiences, subjective judgment, professional experts’ opinions of “best practices,” and marketing and public relations firms’ expertise. Using these methods for choosing outreach approaches does not necessarily mean that state and national strategies to increase SCHIP and Medicaid enrollment are ineffective, especially since much of the literature on “best practices” offer common guidance for successful outreach to uninsured children and families. A number of policy experts suggest the following broad strategies:⁴⁰

Table 7. Suggested Outreach Strategies to Increase Enrollment in Medicaid and SCHIP Programs	
Suggested Strategy	Strategy Encompasses:
1. <i>Simplify the application and enrollment process</i>	Reducing the length of applications; accepting applications by mail, telephone, facsimile, and the Internet; accepting applications at sites other than public assistance (welfare) offices; out-stationing eligibility workers; providing assistance at times convenient for the population being served; arranging to accept applications by others on behalf of clients; easing eligibility verification requirements (e.g., allowing self-declaration of income and assets); aligning eligibility rules between Medicaid and SCHIP programs; coordinating SCHIP and Medicaid application and enrollment procedures; establishing presumptive eligibility and 12-month continuous eligibility for children; implementing “Express Lane Eligibility”

⁴⁰ Center on Budget and Policy Priorities, 1998; HRSA/HCFA, 1998; Brecht Carpenter and Kavanagh, 1998; Pulos and Lynch, 1999; Horner, et al., 1999; Schwalberg, et al., 1999; Summer, Brecht Carpenter, and Kavanagh, 1999; Academy for Educational Development, 1999; Horner, Lazarus, and Morrow, 1999; Cohen Ross and Jacobson, 1999; Cohen Ross, 1999.

Table 7. Suggested Outreach Strategies to Increase Enrollment in Medicaid and SCHIP Programs (cont.)

Suggested Strategy	Strategy Encompasses:
2. <i>Develop consumer-driven marketing strategies</i>	Identifying and understanding the target population; involving the target population in all aspects of designing and planning outreach activities; using a collaborative approach with community-based organizations and agencies to outreach planning and implementation that includes key players who understand the target population; ensuring that messages are clear, simple, personal, and straight-forward; ensuring that all materials use appropriation translation and alter the content to be culturally specific or sensitive for non-English speaking and minority group populations and delivered by trusted members of the community; contacting potentially eligible individuals in settings that offer comfort, safety, and privacy and where clients' circumstances allow time to talk
3. <i>Focus outreach efforts at the local level and follow-up</i>	Involving trusted representatives from communities in the design and implementation of outreach efforts; attending community events; using localized media (small community newspapers, shoppers' guides, flyers); working closely with outreach workers who are experienced with the target population, sensitive in personal interactions, and well-trained about the program; working closely with community-based organizations (CBOs) that can provide active assistance to clients throughout the enrollment process (e.g., acting as "culture brokers" to ease misunderstandings; helping clients with the initial application, with appointments, documentation, follow-up inquiries and information; acting as client advocates when applications go astray or seem to be denied unfairly; and helping clients to overcome linguistic, cultural, and cognitive challenges); providing grants to CBOs to engage in outreach and application assistance
4. <i>Forge public and private partnerships</i>	State Medicaid and SCHIP agencies working with other public insurance programs, public health programs, other related state agencies, private businesses, volunteer groups, advocacy organizations, health providers, churches, schools and day care centers
5. <i>Make person-to-person contacts</i>	Conducting home visits, training-the-trainers, making one-on-one contact at health clinics, schools, and community centers, and providing one-on-one application assistance when needed.
6. <i>Develop a multi-faceted campaign to reach as many uninsured children as possible</i>	Ensuring that materials are available in numerous places to reach the targeted population; including Medicaid and SCHIP flyers in other mailings such as utility bills and church bulletins, or in take-home packets distributed at schools for registration, reports cards, or sports participation; conducting targeted direct mailings; placing notices in newspapers and other publications; using toll-free hotlines for a variety of purposes such as information, referrals, application mailings, accepting applications, HMO selection, and case management; using websites for disseminating information

- b. Choose which outreach interventions to evaluate according to current levels of state-funding for SCHIP/Medicaid outreach activities. Determine which activities states are currently spending the majority of their money on and conduct rigorous evaluations of the effectiveness of these initiatives. They might include state-wide media campaigns, efforts to simplify the application process, or pursuit of community-based approaches. It would be useful for states to know how best to re-direct their funds to optimize their outreach and enrollment efforts. Because many states are initiating school-based outreach, this is also an important area for greater evaluation.⁴¹
- c. Choose which outreach interventions to evaluate based on current issues of pressing concern. The public insurance literature identifies several areas that appear to be significant barriers to enrollment in the Medicaid and SCHIP programs:
- ◆ Fear of INS and “public charge” determinations have been identified as major barriers to enrollment for U.S. immigrants.⁴² Evaluations of the effectiveness of current activities to combat this problem, and widespread dissemination of the most effective activities, would prove very useful for large portions of the uninsured children population.
 - ◆ Rejection of applications for lack of documentation or incomplete applications appears to be a significant cause of low enrollment in many states.⁴³ Evaluation should focus on the primary causes for rejection and the best ways to overcome this problem. Evaluation should also address follow-up to incomplete and rejected applications to determine whether these children are subsequently enrolling in Medicaid or SCHIP. Additionally, it is not known how many children who are denied enrollment in SCHIP because they are eligible for Medicaid are eventually enrolled in the Medicaid program.⁴⁴ Evaluation would involve identifying who these children are, whether they subsequently enroll in Medicaid, and if they do not, reasons for non-enrollment and strategies to successfully address those reasons.
 - ◆ Another problem that appears to need attention is the lack of continuous enrollment in the Medicaid and SCHIP programs (although SCHIP programs are relatively new and re-enrollment problems might not yet be documented). People may fall off of Medicaid due to frequent eligibility redeterminations and off of SCHIP due to lack of ability or desire to pay premiums.⁴⁵

⁴¹ U.S. Department of Health and Human Services, 1999.

⁴² Rundall, et al., 1999; Schwalberg, et al., 1999; Medi-Cal Community Assistance Project, 1999.

⁴³ Perry, et al., 2000.

⁴⁴ Health Care Financing Administration, 2000.

⁴⁵ Perry, et al., 2000.

2. **Ensure that the infrastructure is in place to conduct evaluations.** The data sources and analytic capacity needed for evaluating SCHIP/Medicaid enrollments are unevenly distributed across states.⁴⁶ For example, in an evaluation of California's success in implementing its new SCHIP program, the authors state that "[a]vailable data is less than ideal for determining how many children are in fact eligible for the Healthy Families program compared to the children eligible for Medi-Cal. The imprecision of these estimates has made it difficult to assess the success of California's enrollment efforts."⁴⁷ The Department of Health and Human Services' collection of SCHIP enrollment data from states will help meet some of the data needs.

The necessary measures and measurement tools to conduct evaluation are not yet well-developed for documenting the effectiveness of outreach strategies on SCHIP or Medicaid enrollment.⁴⁸ The American Academy of Pediatrics, however, has created the "SCHIP Evaluation Tool" to assist states in assessing their programs⁴⁹ and Mathematica Policy Research, through HCFA funding, has established a structured state evaluation framework for state SCHIP reporting requirements.⁵⁰ These tools, if widely disseminated and used, should help states conduct higher-quality program assessments.

The administrative and organizational infrastructure, including management information systems for the continuous improvement of enrollment outcomes, is not well-developed.⁵¹ For example, there are often dual and incompatible systems in states with separate Medicaid and SCHIP programs or between pre-existing state programs to cover uninsured children and Medicaid/SCHIP programs.

In addition, there is a general lack of data at the local level to identify families and children who are potentially eligible for these programs in order to develop targeted outreach activities. The characteristics of a community's working poor population and the types of jobs they hold, the percentages that live in rural and urban areas, and the needs of different racial and cultural groups are important information upon which to design targeted outreach and service strategies. Although some national information (collected mainly through surveys such as the Current Population Survey or Medical Expenditure Panel Survey) is available, it is usually only reliable at the national level and cannot capture variations between and within states, much less variations among communities.⁵² Local-level data need to be collected to ensure that outreach efforts are appropriately targeted to local needs.⁵³ One promising approach for identifying uninsured children who might be eligible for SCHIP and Medicaid at the local level is through free and reduced school lunch program applications. A federal inter-governmental effort is underway to make it more feasible for this type of identification process to be used (e.g., confidentiality issues may currently limit access to free and reduced school lunch application information).

⁴⁶ Halfon, et al., 1999.

⁴⁷ Medi-Cal Community Assistance Project, 1999.

⁴⁸ See, for example, Medi-Cal Community Assistance Project, 1999; or Coulam and Levinson, 1995.

⁴⁹ American Academy of Pediatrics, 1998.

⁵⁰ Conversation with Margo Rosenbach, Mathematica Policy Research, January 26, 2000.

⁵¹ Halfon, et al., 1999; Medi-Cal Community Assistance Project, et al., 1999; Schwalberg, et al., 1999.

⁵² See, for example, Ullman, Bruen, and Holahan, 1999.

⁵³ Brecht Carpenter and Kavanagh, 1998.

3. **Assist with the implementation and conduct of high-quality rigorous evaluations.** Community-based and state-level organizations often do not have the capacity or funding to pursue rigorous, methodologically-sound evaluation. Assistance in ensuring that experienced researchers with training in evaluation methodologies are involved in the design and conduct of outreach evaluations, and that data collection and program evaluation become integral parts of an outreach program's design and budget, will go a long way in determining effective practices.
4. **Evaluate effective outreach strategies for racial/ethnic minority groups and other populations that are under-enrolled.** The U.S. Census Bureau has found that of poor uninsured children, 33.3 percent are of Latino descent, 27.7 percent are non-Hispanic White, 21.5 percent are African American, and 17.1 percent are Asian and Pacific Islander.⁵⁴ In some states, racial or ethnic minorities comprise an even larger share of uninsured children. In California, for example, Latinos account for 75 percent of children eligible for its SCHIP program (Healthy Families) but make up less than 50 percent of children enrolled. African Americans are similarly under-represented in California's SCHIP program.⁵⁵ Because of the high percentage of racial and ethnic minority children who are uninsured, evaluations should also focus on the types of particular outreach activities that are most effective for reaching populations with distinct language and cultural backgrounds.
5. **Conduct literature reviews and syntheses of evaluations of promising interventions.** The large number of evaluations in progress on what we have characterized as "case management/advocacy intervention" should be carefully reviewed and synthesized to enhance our understanding of what makes these programs effective and also of how to make them cost effective. Additionally, in our search of the evaluation literature on outreach interventions for public insurance programs, we discovered a wealth of information about interventions that work or do not work to increase such public health services as child immunizations, well-child care screenings, prenatal services, asthma health care services, HIV and AIDs prevention services, and others. Because of its breadth and volume, this body of literature is beyond the scope of this report; however, it could very well help illuminate effective practices for increasing public insurance program enrollment. For example, there is a growing evaluation literature on the use of community coalitions to improve the health status of a community/and or to improve the availability and access to health and medical care services.⁵⁶

Future research efforts might first identify interventions that are most commonly used in SCHIP outreach, such as case management, mass media, telephone hotlines, community coalitions, or application simplification, and then determine what the public health literature can tell us about which of these interventions appear to be most promising for increasing SCHIP enrollment, for which populations, under what circumstances, and for which communities or settings. The challenge will be to determine whether interventions that are effective for increasing use of or access to public health services are likely to be as effective for increasing enrollment in public insurance programs. Use of a health service may be a less complicated process than the process of obtaining and completing an application for

⁵⁴ U.S. Census Bureau, 1998.

⁵⁵ Medi-Cal Community Assistance Project, 1999.

⁵⁶ See, for example, a review of this literature in Kreuter and Lezin, 1998.

insurance and providing required documentation. The benefits from a health service may also be more immediate and obvious than health insurance benefits. Although we did not review this body of literature, we do provide references to many of these articles in the bibliography as a starting point for such literature reviews.

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APPENDIX A:

**TABLE 1. OUTREACH STEPS ADDRESSED BY COMPLETED EVALUATION
STUDIES AND EVALUATION STUDIES IN PROGRESS**

**Table 1. Outreach Steps Addressed by Completed Evaluation Studies
and by Evaluation Studies In Progress**

Completed Evaluation Studies (Pages A1 – A5)

Outreach Step(s)	Type of Intervention(s)	Research Objective	Study Citation
<p>Step 1: Identify and understand target populations</p> <p>Step 2: Increase public awareness that the program exists</p> <p>Step 3: Increase understanding of who is eligible for the program</p> <p>Step 4: Educate individuals about the program</p> <p>Step 5: Motivate individuals to take action to find out more about, or enroll in, the program</p> <p>Step 6: Facilitate individuals' actions needed to enroll in the program</p>	<p>Case management/advocacy:</p> <ul style="list-style-type: none"> ◆ 26 local social-service organizations funded to identify potentially eligible children, increase awareness of the Food Stamp Program, and facilitate enrollment in the program ◆ Grantees employed a variety of activities: establish public/private collaboration (partnering); client identification activities (door-to-door canvassing; partnering for client lists and contacts; screening clients who came to the agency for other types of assistance; outreach workers visiting other offices, sites or events which their target population or the general public frequents); public information and education services (mass media – radio, TV, newspapers; PSAs; flyers, fact sheets, posters, and brochures; newspaper and newsletter articles; toll-free telephone lines; small group presentations); alternative sites/methods/times for applying (alternative sites, flexible office hours, accepted applications from grantee staff on behalf of clients); a wide range of application assistance services and follow-up and advocacy services (one-on-one assistance). Only a few projects conducted all of these activities 	<p>Assess which methods of outreach and client assistance (i.e., case management) are most effective in helping eligible but non-enrolled persons enroll in the Food Stamp Program</p>	<p>LTG Associates, Inc. (July 1999), <u>Food Stamp Program Client Enrollment Assistance Demonstration Projects: Final Evaluation Report</u>, report prepared for the U.S. Department of Agriculture, Food and Nutrition Service</p>

Table 1. Outreach Steps Addressed by Completed Evaluation Studies and by Evaluation Studies In Progress			
<p>Step 1: Identify and understand target populations</p> <p>Step 2: Increase public awareness that the program exists</p> <p>Step 3: Increase understanding of who is eligible for the program</p> <p>Step 4: Educate individuals about the program</p> <p>Step 5: Motivate individuals to take action to find out more about, or enroll in, the program</p> <p>Step 6: Facilitate individuals' actions needed to enroll in the program</p>	<p>Case management/advocacy:</p> <ul style="list-style-type: none"> ◆ Home visits by teams of workers that included registered nurses, social workers, and indigenous community health workers (i.e., case management, or care coordination, for pregnant Medicaid recipients) ◆ Home visits included assessment, development of a plan of care, education, social support, referral, and counseling ◆ Referrals were obtained from clinics and other community agencies, self-referral, general out-reach, and targeted case-finding by the community health workers ◆ A care-coordination team followed women through their pregnancies and for at least three months postpartum ◆ Participants received telephone visits and visits at such sites as the care-coordination offices, prenatal clinics, or agencies where enrollment in the pregnancy-related services occurred ◆ Community health workers accompanied some participants to their enrollment appointments 	<p>Assess the effectiveness of home visits (i.e., case management) on enrollment in WIC, Medicaid, and the Food Stamp Program</p>	<p>Bradley, P. J., and Martin, J. (December 1994), "The Impact of Home Visits on Enrollment Patterns in Pregnancy-Related Services Among Low-Income Women," <u>Public Health Nursing</u>, 11(6): 392-8</p>
<p>Step 2: Increase public awareness that the program exists</p> <p>Step 3: Increase understanding of who is eligible for the program</p>	<p>"Direct outreach":¹</p> <ul style="list-style-type: none"> ◆ Measured by the county's expenditures on Pennsylvania's Healthy Beginnings Program (included adoption of presumptive eligibility) <p>"Indirect outreach":²</p> <ul style="list-style-type: none"> ◆ Measured by the percentage of the county's potentially-eligible population enrolled in WIC ◆ Measured by the county's Department of Public Welfare expenditures on social services 	<p>Assess whether county government outreach expenditures improve enrollment in non-mandatory Medicaid assistance for households that do not automatically qualify for benefits (e.g., through AFDC or SSI)</p>	<p>Stine, W. F. (Summer 1991), "The Effect of Local Government Outreach Efforts on the Reciprocity of Selected Medicaid Programs," <u>Inquiry</u>, 28: 161-8</p>

Table 1. Outreach Steps Addressed by Completed Evaluation Studies and by Evaluation Studies In Progress			
<p>Step 2: Increase public awareness that the program exists</p> <p>Step 3: Increase understanding of who is eligible for the program</p>	<ul style="list-style-type: none"> ◆ Chinese radio and television announcements, as part of the promotional efforts of a local community health clinic in San Francisco's Chinatown, North East Medical Services (NEMS) ◆ Other Chinatown social service providers also took part in promoting Healthy Families through referrals to NEMS, Healthy Families telemarketing, and Healthy Families workshops 	<p>Assess community-based efforts in San Francisco's Chinese community to enroll uninsured children in California's new SCHIP program (Healthy Families)</p>	<p>Grant, D., et al., (July 1999), <u>Healthy Families at Year One: Outreach, Application, and Enrollment Issues</u>, a report by the Medi-Cal Community Assistance Project, a cooperative project of Families USA, Health Access Foundation, Latino Issues Forum, and Community Health Councils, Inc. (supported by a grant from The California Wellness Foundation)</p>
<p>Step 5: Motivate individuals to take action to find out more about, or enroll in, the program</p>	<p>Positioning a program like "private insurance" instead of "welfare" to reduce public welfare stigma issues:</p> <ul style="list-style-type: none"> ◆ Maine's program built upon the existing Medicaid infrastructure and was viewed simply as another category of Medicaid eligibility ◆ South Carolina's and Washington's programs pursued innovative efforts to privatize or decentralize Medicaid-like coverage, by positioning the coverage as "insurance" rather than simply "claims payment." Both programs deliberately avoided a direction association with Medicaid 	<p>Assess the performance of three state demonstrations that allowed states to extend Medicaid coverage to certain low-income families not otherwise qualified to receive Medicaid benefits, with respect to enrollment, costs and utilization, and access and satisfaction</p>	<p>Rosenbach, M. L., et al., (December 1997), <u>Evaluation of the Medicaid Demonstration: Revised Final Report</u>, prepared by Health Economics Research, Inc., Research Triangle Institute, and the University of Washington, for the Health Care Financing Administration</p>

Table 1. Outreach Steps Addressed by Completed Evaluation Studies and by Evaluation Studies In Progress			
Step 7: Address systemic barriers to enrollment or action	Simplified application procedures: ◆ Dropped assets testing ◆ Designed one-page application ◆ Out-stationed Medicaid eligibility workers (FL only)	Assess whether eligibility expansions for Medicaid financing of deliveries, combined with aggressive outreach, lead to a significant increase in Medicaid-financed deliveries in Florida and Oregon	Mayer, J. (1992), "A Time Series Study of the Impact of Eligibility Expansion on Medicaid Financing of Births," <u>Journal of Health & Social Policy</u> , 4(2): 1-17
Step 8: Change state policies and program characteristics to address barriers to enrollment	Adopted presumptive or expedited eligibility Adopted continuous eligibility		
Step 2: Increase public awareness that the program exists (not the main focus of the evaluation)	Instituted maternity telephone hot-line (FL only) PSAs on radio and TV Case-finding by outreach workers Other notification efforts (brochures, posters, mailings to human service clients and Medicaid providers)		
Step 7: Address systemic barriers to enrollment or action	Simplified application procedures: ◆ Dropped assets testing ◆ Out-stationed eligibility workers ◆ Shortened the application form for pregnant women	Assess how the Medicaid expansions in income eligibility levels for pregnant women, implemented in four states over the period 1987-1991, affected access to prenatal care for low-income women	Dubay, L. C., Kenney, G. M., Norton, S. A., and Cohen, B. C. (1995), "Local Responses to Expanded Medicaid Coverage for Pregnant Women," <u>The Milbank Quarterly</u> , 4(73): 535-63
Step 8: Change state policies and program characteristics to address barriers to enrollment	Adopted either expedited or presumptive eligibility Adopted continuous eligibility		
Step 2: Increase public awareness that the program exists (not the main focus of the evaluation)	Publicity campaigns to advertise the expansion: ◆ Implemented large-scale multi-media campaigns ◆ Advertisement of referral hotlines for pregnant women ◆ Inserted expansion information into utility bills/WIC mailings		

Table 1. Outreach Steps Addressed by Completed Evaluation Studies and by Evaluation Studies In Progress			
Step 8: Change state policies and program characteristics to address barriers to enrollment	Adoption of presumptive eligibility for low-income pregnant women	Assess the effects of presumptive eligibility for Medicaid on the receipt of prenatal care and the occurrence of low-birthweight births and neonatal, perinatal, and infant mortality	Piper, J. M., Mitchel, E. F., Jr., and Ray, W. A. (October 1994), "Presumptive Eligibility for Pregnant Medicaid Enrollees: Its Effects on Prenatal Care and Perinatal Outcome," <u>American Journal of Public Health</u> , 84(10): 1626-1630
Step 7: Address systemic barriers to enrollment or action	<p>Simplified application form and enrollment process:</p> <ul style="list-style-type: none"> ◆ KidCare process eliminated the face-to-face interview ◆ Single application form developed for Florida Healthy Kids, MediKids, Medicaid, or Children's Medical Services (all KidCare Program components) ◆ Families no longer have to document income level or provide face-to-face verification 	Assess whether families enrolled in Florida's Healthy Kids Program, who were required to reapply to determine Medicaid eligibility due to Florida's SCHIP initiative (KidCare), actually became enrolled in the Medicaid program and to determine their satisfaction with the new simplified enrollment process	Bono, C. A., Shenkman, E., and Hope-Wegener, D. (June 1999), <u>KidCare: The Impact on Medicaid Eligibles in the Healthy Kids Program, A Six Month Follow-Up Report</u> , a report prepared for the Healthy Kids Board of Directors
Step 8: Change state policies and program characteristics to address barriers to enrollment	Effective January 1, 1999, children from birth to five years of age entitled to 12 months of continuous eligibility		

**Table 1. Outreach Steps Addressed by Completed Evaluation Studies
and by Evaluation Studies In Progress**

Evaluation Studies In Progress (Pages A6 – A13)

Outreach Step(s)	Type of Intervention(s)	Research Objective	Study Identification
<p>Step 1: Identify and understand target populations</p> <p>Step 2: Increase public awareness that the program exists</p> <p>Step 3: Increase understanding of who is eligible for the program</p> <p>Step 4: Educate individuals about the program</p> <p>Step 5: Motivate individuals to take action to find out more about, or enroll in, the program</p> <p>Step 6: Facilitate individuals' actions needed to enroll in the program</p>	<p>Case management/advocacy:</p> <ul style="list-style-type: none"> ◆ Outreach workers employ a variety of strategies to contact and enroll families; three primary strategies employed are: <ul style="list-style-type: none"> ◇ Liaisoning with key community institutions by providing them with written materials and conducting workshops ◇ Attending community events (health and neighborhood fairs and ethnic celebrations; providing advice about the Medi-Cal system; distributing fact sheets, advertising flags, and information cards) ◇ Making person-to-person contacts (home visits, train-the-trainers, one-on-one contact at community health clinics and schools) 	<p>Assess the effectiveness of the 10 First Things First community coalitions' outreach approaches to increasing Medi-Cal (California's Medicaid program) enrollment of eligible children</p>	<p><u>Evaluation of the First Things First Initiative.</u> University of California, Berkeley School of Public Health, Center for Health Management Studies, in collaboration with the Institute for Health Policy Studies, University of California at San Francisco; contact Thomas G. Rundall, Berkeley School of Public Health</p>
<p>Step 1: Identify and understand target populations</p> <p>Step 2: Increase public awareness that the program exists</p> <p>Step 3: Increase understanding of who is eligible for the program</p> <p>Step 4: Educate individuals about the program</p> <p>Step 5: Motivate individuals to take action to find out more about, or enroll in, the program</p>	<p>Case management/advocacy:</p> <ul style="list-style-type: none"> ◆ Six community-based outreach worker grants to identify potentially eligible children, increase awareness of the NJKidcare program, and facilitate enrollment in the program (50% of funding dependent on meeting application targets) ◆ School-based identification of potentially eligible children through screener sent home to all children, returned to school, followed-up by application sent to families who may be eligible, and matching of these families to the community-based outreach workers to assist with application completion and follow-up if needed 	<p>Assess the effectiveness of a community-level approach to increasing enrollment in SCHIP programs (NJKidcare is New Jersey's SCHIP program); relative assessment of effectiveness of community-based outreach worker activities to increase SCHIP enrollment</p>	<p><u>Evaluation of Outreach and Promotion Activities Related to Increasing Participation Among Hispanic/Latino Children in NJKidcare in Hudson County, NJ.</u> Barents Group LLC; contact Lisa Green or Kenneth Cahill</p>

Table 1. Outreach Steps Addressed by Completed Evaluation Studies and by Evaluation Studies In Progress			
Step 6: Facilitate individuals' actions needed to enroll in the program	<ul style="list-style-type: none"> ◆ Public relations activities to raise awareness of NJKidcare and availability of outreach worker assistance through press conferences, radio remotes (via Spanish-language radio stations, health fairs, give-aways), and "earned media" approach (i.e., create media interest through other outreach activities) 		
<p>Step 1: Identify and understand target populations</p> <p>Step 2: Increase public awareness that the program exists</p> <p>Step 3: Increase understanding of who is eligible for the program</p> <p>Step 4: Educate individuals about the program</p> <p>Step 5: Motivate individuals to take action to find out more about, or enroll in, the program</p> <p>Step 6: Facilitate individuals' actions needed to enroll in the program</p>	<p>Case management/advocacy:</p> <ul style="list-style-type: none"> ◆ 14 community coalitions funded to identify potentially eligible children, increase awareness of the MICHild and Healthy Kids programs, and facilitate enrollment in the programs <ul style="list-style-type: none"> ◇ Grantees employ a variety of activities, including "bounty system" of paying teen recruiters per enrolled child; use of portable photocopier for home application assistance; door-to-door outreach by volunteer "community ambassadors"; telephone hot-line; direct application assistance and follow-up; training of health providers and community health advocates; out-stationing of outreach workers; development of bi-lingual educational and presentation materials; school- and church-based activities; advertisements such as posters on public buses 	Assess the most effective means for identifying and enrolling children in Michigan's Medicaid ("Healthy Kids") and SCHIP ("MICHild") programs through community coalitions and, to the extent possible, determine whether activities funded under the BCBS grant have increased enrollment in the targeted communities compared with comparable communities that did not receive BCBS funding	<p><u>Evaluation of the Seek-Find-Enroll Initiative.</u></p> <p>Contact Jack Wheeler, School of Public Health, University of Michigan, or Gary Freed, Division of Pediatrics, University of Michigan Medical Center</p>

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<p>Step 1: Identify and understand target populations</p> <p>Step 2: Increase public awareness that the program exists</p> <p>Step 3: Increase understanding of who is eligible for the program</p> <p>Step 4: Educate individuals about the program</p> <p>Step 5: Motivate individuals to take action to find out more about, or enroll in, the program</p> <p>Step 6: Facilitate individuals' actions needed to enroll in the program</p>	<p>Case management/advocacy:</p> <ul style="list-style-type: none"> ◆ “Coalition” model of outreach and enrollment: <ul style="list-style-type: none"> ◇ In two sites in Pennsylvania (Philadelphia and 4 surrounding counties; Fayette, Washington, and Green Counties), 10 agencies are paid \$25 from an RWJ-funded enrollment fund for each application they assist in completing for Pennsylvania’s SCHIP and Medicaid programs. In addition, the 10 agencies in Fayette, Washington, and Green Counties have formed a coalition with a variety of other agencies and providers that serve SCHIP-eligible families (in particular Children’s Hospital) to assist families through the enrollment process ◆ “Community health worker” model of outreach and enrollment: <ul style="list-style-type: none"> ◇ In two sites in Pennsylvania (York and Allegheny Counties), two community health outreach workers have been hired to help increase awareness of SCHIP and Medicaid programs and provide application and enrollment assistance 	<p>Assess the effectiveness of outreach and enrollment efforts through two different models of community-based outreach (the “coalition” model and the “community health worker” model)</p>	<p><u>Evaluation of Four Pilot Projects to Increase SCHIP and Medicaid Enrollment in Pennsylvania Under the Children’s Health Coverage Campaign.</u> Consumer Health Coalition (Pennsylvania’s Partnership for Children); contact Ann Bacharach</p>

**Table 1. Outreach Steps Addressed by Completed Evaluation Studies
and by Evaluation Studies In Progress**

<p>Step 1: Identify and understand target populations</p> <p>Step 2: Increase public awareness that the program exists</p> <p>Step 3: Increase understanding of who is eligible for the program</p> <p>Step 4: Educate individuals about the program</p> <p>Step 5: Motivate individuals to take action to find out more about, or enroll in, the program</p> <p>Step 6: Facilitate individuals' actions needed to enroll in the program</p>	<p>Case management/advocacy:</p> <ul style="list-style-type: none"> ◆ Use of school-based outreach workers/application assistants, who are given access to schools' lists of parents likely to be interested in Medicaid and SCHIP programs; telephone these parents, send fliers home with children, go to open houses, work with Parent-Teacher organizations and school nurses, invite parents to come to school for application assistance, photocopy and mail applications on behalf of parents, help parents in their communications with government eligibility and application-processing agencies when necessary 	<p>Assess the use of schools as vehicles to reach low-income families with uninsured children who are eligible for Medicaid and SCHIP programs and as a way to teach parents about the importance of health insurance and how to use preventive benefits offered by insurance plans; develop a school-based outreach and application "formula" that can be replicated in other school districts</p>	<p><u>Evaluation of the Health-insurance Access Through Schools: "HATS" Project.</u> School Health and Community Pediatrics Division, University of California-San Diego; contact Howard Taras</p>
<p>Step 1: Identify and understand target populations</p> <p>Step 2: Increase public awareness that the program exists</p> <p>Step 3: Increase understanding of who is eligible for the program</p> <p>Step 4: Educate individuals about the program</p> <p>Step 5: Motivate individuals to take action to find out more about, or enroll in, the program</p> <p>Step 6: Facilitate individuals' actions needed to enroll in the program</p>	<p>Case management/advocacy:</p> <ul style="list-style-type: none"> ◆ MHRA, which administers the WIC program in New York, placed employees in either three WIC centers in Brooklyn (the "WIC Center Model") or in a small business that participates in WIC on a contract basis with New York (the "Small Business Model") ◆ In the WIC Center Model, MHRA employees acted as facilitators to identify, educate, and help enroll children in Child Health Plus (CHP). MHRA employees, who can determine eligibility, were also placed in the businesses participating in the Small Business model to help enroll eligible children. Participating businesses were also asked to help increase awareness of the CHP program 	<p>Assess the effectiveness of two different outreach and enrollment strategies to enroll eligible uninsured children in New York's Medicaid and SCHIP (Child Health Plus) programs</p>	<p><u>Testing Outreach and Enrollment Strategies for Insuring Low-Income Children in New York City.</u> Medical and Health Research Association of New York City; contact David Sandman</p>

Table 1. Outreach Steps Addressed by Completed Evaluation Studies and by Evaluation Studies In Progress			
<p>Step 1: Identify and understand target populations</p> <p>Step 2: Increase public awareness that the program exists</p> <p>Step 3: Increase understanding of who is eligible for the program</p> <p>Step 4: Educate individuals about the program</p> <p>Step 5: Motivate individuals to take action to find out more about, or enroll in, the program</p> <p>Step 6: Facilitate individuals' actions needed to enroll in the program</p>	<p>Case management/advocacy:</p> <ul style="list-style-type: none"> ◆ Visits by a trained outreach worker to the homes of potentially eligible children is the primary intervention in Lake County. Lake County is a rural county in which access to transportation is often a barrier ◆ San Francisco county intervention is more complex, involving a number of collaborators in identifying eligible children, training workers, and providing one-on-one assistance to complete applications 	<p>Develop a data collection methodology and process for evaluating pilot projects in San Francisco and Lake County, California. Client intake and client encounter forms were designed to track the number of applications completed, the number of individuals enrolled, and the number of hours for an outreach worker to complete an application</p>	<p><u>Evaluation of RWJ Covering Kids Pilot Projects in California</u>. University of California-San Diego, Center for Child Health Outcomes; contact Kim Dennis</p>
<p>Step 2: Increase public awareness that the program exists</p> <p>Step 3: Increase understanding of who is eligible for the program</p> <p>Step 4: Educate individuals about the program</p> <p>Step 5: Motivate individuals to take action to find out more about, or enroll in, the program</p> <p>Step 6: Facilitate individuals' actions needed to enroll in the program</p>	<p>Two broad intervention strategies:</p> <ul style="list-style-type: none"> ◆ State-wide information dissemination activities ◆ Training community-based organizations and individuals to provide direct application assistance 	<p>Assess the design and adoption of SCHIP by states; assess state strategies to increase SCHIP enrollment, with a focus on enrollment processes; assess the relative effectiveness of two broad strategies: state-wide information dissemination activities vs. training community-based organizations and individuals to provide direct application assistance</p>	<p><u>Monitoring and Evaluating the State Children's Health Insurance Program (SCHIP)</u>. Urban Institute; contact Ian Hill, Genevieve Kenney, or Lisa Dubay</p>

Table 1. Outreach Steps Addressed by Completed Evaluation Studies and by Evaluation Studies In Progress			
<p>Step 2: Increase public awareness that the program exists</p> <p>Step 3: Increase understanding of who is eligible for the program</p> <p>Step 4: Educate individuals about the program</p> <p>Step 1: Identify and understand target populations</p> <p>Step 2: Increase public awareness that the program exists</p> <p>Step 3: Increase understanding of who is eligible for the program</p> <p>Step 4: Educate individuals about the program</p> <p>Step 5: Motivate individuals to take action to find out more about, or enroll in, the program</p> <p>Step 6: Facilitate individuals' actions needed to enroll in the program</p>	<p>◆ Direct mailings to inform women of their child's potential eligibility for Kidcare</p> <p>◆ Door-to-door outreach to inform women about the program and help them complete a Kidcare application; door-to-door outreach will be conducted by local Healthy Start coalitions</p>	<p>Assess the effectiveness of two specific outreach strategies to encourage women coming off of Florida's Welfare-to-Work program to enroll their children in Florida's SCHIP program (Kidcare)</p>	<p><u>Evaluation of the Effectiveness of Outreach Strategies to Encourage Enrollment in Florida's Kidcare Program for Recent Welfare-to-Work Recipients.</u> University of Florida, Gainesville, FL; contact Elizabeth Shenkman</p>
<p>Step 2: Increase public awareness that the program exists</p>	<p>A variety of state outreach activities will be included in questionnaire, but activities are not yet specified in survey design</p>	<p>Assess whether and how parents heard about either Oregon's SCHIP Medicaid-look-alike program or its premium subsidy program</p>	<p><u>Medicaid vs. Premium Subsidy: Oregon's CHIP Alternatives.</u> Center for Health Economics Research; contact Janet Mitchell</p>

Table 1. Outreach Steps Addressed by Completed Evaluation Studies and by Evaluation Studies In Progress			
Step 2: Increase public awareness that the program exists	A variety of state outreach activities, but specific activities to be asked about in the survey are not yet specified	Assess how parents of children enrolled in Florida's SCHIP program (Kidcare) found out about the program; results will be used to help assess relative effectiveness of various state outreach activities to increase program awareness	<u>Evaluation of Florida's SCHIP Program (Kidcare)</u> . University of Florida, Gainesville, FL; contact Elizabeth Shenkman
Step 2: Increase public awareness that the program exists	A variety of state outreach activities, but specific activities to be asked about in the survey are not yet specified	Assess whether parents of children eligible for Florida's SCHIP program (Kidcare) had heard of the program, and if so, how they had heard about it; results will be used to help assess relative effectiveness of various state outreach activities to increase program awareness	<u>Estimates of the Number of Uninsured in Florida</u> . University of Florida, Gainesville, FL; contact Elizabeth Shenkman
Step 7: Address systemic barriers to enrollment or action	Premium subsidies: ♦ Four types of contracts were subsidized under the Access Program: single; married couple; one parent and up to two children; and family (two parents and up to two children); the subsidies allowed families to buy private insurance under the IHCP	Assess the impact of subsidies on enrollment rates in the Health Access New Jersey (Access Program), a short-lived premium subsidy program	<u>Evaluation of the New Jersey Access Program</u> . Department of Health Policy and Management, Harvard School of Public Health; contact Katherine Swartz
Dependent on state outreach activities; it is assumed that states have addressed or are addressing all outreach steps	Outreach activities implemented by 50 state SCHIP agencies	Assess state rankings of the relative effectiveness of different outreach interventions used to increase SCHIP enrollment	<u>Synthesis of State Evaluations of SCHIP Programs</u> . Mathematica Policy Research, Inc.; contact Margo Rosenbach

Table 1. Outreach Steps Addressed by Completed Evaluation Studies and by Evaluation Studies In Progress			
Dependent on outreach activities evaluated in the literature reviewed	As reported in the literature reviewed for the literature review and synthesis of evaluations of effective SCHIP outreach activities	Assess the relative effectiveness of outreach activities for increasing enrollment in SCHIP programs	<u>Literature Review and Synthesis of Evaluations of Outreach Interventions to Increase Enrollment in SCHIP Programs.</u> Mathematica Policy Research, Inc.; contact Margo Rosenbach
Dependent on states and their outreach activities that are selected for the study	Specific interventions to be included in study will be determined by on-going activities in states selected for the study	Assess SCHIP enrollment processes, effectiveness of outreach activities, effectiveness of outreach messages, etc., as well as assess reasons for enrollment, disenrollment, or non-enrollment in SCHIP programs, from the consumer's perspective	<u>Evaluation of Effectiveness of SCHIP Enrollment Processes and Outreach Interventions from the Consumer Perspective.</u> Mathematica Policy Research, Inc.; contact Margo Rosenbach
Dependent on state outreach activities; it is assumed that states have addressed or are addressing all outreach steps	Outreach activities pursued by the 50 states and District of Columbia	Assess whether particular state-funded outreach activities or the intensity of state outreach efforts lead to a significant increase in SCHIP enrollment in the state	<u>Evaluation of the Effectiveness of States' Outreach Efforts on SCHIP Enrollment.</u> Mathematica Policy Research, Inc.; contact Margo Rosenbach

¹According to the study, "direct outreach" efforts attempt to increase the number of recipients by directly enlisting a targeted population into a medical assistance program. Pennsylvania's Healthy Beginnings Program, implemented on April 1, 1988, provides Medical Assistance coverage to pregnant women and to children under the age of four in families with incomes below 100% of the poverty level. Pregnant women can receive prenatal care on a presumptive eligibility basis for a maximum of 45 days.

²According to the study, "indirect outreach" efforts attempt to stimulate Medicaid enrollment by first involving eligible persons in another program, under the assumption that contact with other social service programs improves the level of information individuals have and their accessibility to related programs. The more often the potentially-eligible Medicaid population interacts with other social service agencies, the greater the probability these individuals will receive Medical Assistance. WIC is an example of indirect outreach in this study, which is partially funded by the Pennsylvania Department of Health. Social services funded under Pennsylvania's Department of Public Welfare are other examples of indirect outreach in this study.

APPENDIX B:
SEARCH TERMS AND OUTCOMES FROM DATABASE SEARCHES

SEARCH TERMS AND OUTCOMES FROM DATABASE SEARCHES

1. “Evaluation of outreach activities”:
 - ◆ 34 citations in HealthStar,
 - ◆ 3104 citations in CINAHL,
 - ◆ 0 citations in MEDLINE, and⁵⁸
 - ◆ 0 citations in GenMed.
2. “Evaluation” and “outreach”:
 - ◆ 214 citations in HealthStar,
 - ◆ 278 citations in MEDLINE, and
 - ◆ 439 citations in GenMed.
3. “Evaluation of outreach for children’s programs”:
 - ◆ 27 citations in HealthStar,
 - ◆ 0 citations in MEDLINE, and
 - ◆ 0 citations in GenMed.
4. “Evaluation” of “ Children’s Health Insurance Program”:
 - ◆ 32 citations in HealthStar,
 - ◆ 0 citations in MEDLINE, and
 - ◆ 0 citations in GenMed.
5. “Evaluation” and “Children’s Health Insurance Program”:
 - ◆ 0 citations in CINAHL.
6. “Evaluation” and “CHIP”:
 - ◆ 18 citations in CINAHL.
7. “Evaluation” and “children’s programs”:
 - ◆ 483 citations in HealthStar,
 - ◆ 18 citations in MEDLINE, and
 - ◆ 95 citations in GenMed.
8. “Evaluation of outreach to low-income families”
 - ◆ 13 citations in HealthStar,
 - ◆ 0 citations in MEDLINE, and
 - ◆ 0 citations in GenMed.

⁵⁸ Zero citations in MEDLINE indicates that the search terms are too broad.

9. “Evaluation” and “low-income families”:
 - ◆ 35 citations in HealthStar,
 - ◆ 26 citations in MEDLINE, and
 - ◆ 138 citations in GenMed.
10. “Evaluation” of “Medicaid”:
 - ◆ 375 citations in HealthStar,
 - ◆ 407 citations in MEDLINE, and
 - ◆ 21 citations in GenMed.
11. “Evaluation of Medicaid”:
 - ◆ 8 citations in MEDLINE.
12. “Evaluation” and “Medicaid” and “Enrollment”:
 - ◆ 3 citations in CINAHL.
13. “Evaluation” and “National School Lunch Program”:
 - ◆ 0 citations in MEDLINE.
14. “Evaluation of National School Lunch Program”:
 - ◆ 0 citations in MEDLINE.
15. “Evaluation” and “School” and “Lunch”:
 - ◆ 1 citation in CINAHL.
16. “Evaluation” and “SSI”:
 - ◆ 0 citations in MEDLINE.
17. “Evaluation of SSI”:
 - ◆ 0 citations in MEDLINE.
18. “Evaluation of supplemental security income”:
 - ◆ 0 citations in MEDLINE.
19. “Evaluation” and “TANF”:
 - ◆ 1 citation in MEDLINE.

20. “Evaluation” of “TANF”:
- ◆ 5 citations in HealthStar,
 - ◆ 0 citations in MEDLINE, and
 - ◆ 0 citations in GenMed.
21. “Evaluation” of “WIC”:
- ◆ 27 citations in HealthStar,
 - ◆ 4 citations in MEDLINE, and
 - ◆ 6 citations in GenMed.
22. “Evaluation” and “Food Stamps”:
- ◆ 18 citations in MEDLINE, and
 - ◆ 3 citations in CINAHL.
23. “Evaluation” and “Immunizations”:
- ◆ 0 citations in MEDLINE.
24. “Evaluation” and “School-Based Health Centers”:
- ◆ 9 citations in MEDLINE.
25. “Evaluation of school-based health centers”:
- ◆ 0 citations in MEDLINE.
26. “Evaluation and marketing”:
- ◆ 429 citations in HealthStar,
 - ◆ 9 citations in MEDLINE, and
 - ◆ 4 citations in GenMed.
27. “Evaluation” and “marketing”:
- ◆ 429 citations in HealthStar,
 - ◆ 531 citations in MEDLINE, and
 - ◆ 877 citations in GenMed.
28. “Evaluation of marketing”:
- ◆ 429 citations in HealthStar, and
 - ◆ 3 citations in GenMed.
29. “Impact” and “EPSDT”:
- ◆ 6 citations in HealthStar,
 - ◆ 8 citations in MEDLINE, and
 - ◆ 46 citations in GenMed.

30. “Impact” and “Medicaid”:
- ◆ 436 citations in HealthStar,
 - ◆ 429 citations in MEDLINE, and
 - ◆ Over 1,000 citations in GenMed.⁵⁹
31. “Impact” and “Outreach” and “Medicaid”:
- ◆ 10 citations in CINAHL.
32. “Impact” and “Enrollment” and “Medicaid”:
- ◆ 16 citations in CINAHL.
33. “Impact” and “Children’s Health Insurance Program”:
- ◆ 30 citations in HealthStar,
 - ◆ 2 citations in MEDLINE,
 - ◆ 38 citations in GenMed, and
 - ◆ 0 citations in CINAHL.
34. “Impact” and “Immunizations” and “Evaluation”:
- ◆ 86 citations in MEDLINE.
35. “Impact” and “CHIP”:
- ◆ 2 citations in MEDLINE, and
 - ◆ 39 citations in CINAHL.
36. “Impact” and “CHIP” and “Enrollment”:
- ◆ 2 citations in CINAHL.
37. “Impact” and “TANF”:
- ◆ 3 citations in HealthStar,
 - ◆ 2 citation in MEDLINE, and
 - ◆ 7 citations in GenMed.
38. “Impact” and “WIC”:
- ◆ 19 citations in HealthStar,
 - ◆ 26 citations in MEDLINE, and
 - ◆ 133 citations in GenMed.

⁵⁹ If there are over 1,000 hits on a search term, GenMed will not pull up the citations (in the Lexis-Nexis version of GenMed).

39. “Impact” and “WIC” and “Outreach”:
- ◆ 6 citations in CINAHL.
40. “Impact” and “School-Based Health Centers”:
- ◆ 3 citations in MEDLINE.
41. “Impact” and “Head Start”:
- ◆ 6 citations in MEDLINE.
42. “Impact” and “Food Stamps”:
- ◆ 19 citations in MEDLINE,
 - ◆ 15 citations in GenMed, and
 - ◆ 15 citations in CINAHL.
43. “Impact” and “National School Lunch Program”:
- ◆ 0 citations in MEDLINE.
44. “Impact” and “School” and “Lunch”:
- ◆ 3 citations in CINAHL.
45. “Impact” and “Immunizations”:
- ◆ 733 citations in MEDLINE.
46. “Outcomes” and “EPSDT”:
- ◆ 4 citations in HealthStar,
 - ◆ 8 citations in MEDLINE, and
 - ◆ 42 citations in GenMed.
47. “Outcomes” and “Medicaid”:
- ◆ 354 citations in HealthStar,
 - ◆ 560 citations in MEDLINE, and
 - ◆ Over 1,000 citations in GenMed.
48. “Outcomes” and “Medicaid” and “Evaluation”:
- ◆ 85 citations in MEDLINE.
49. “Outcomes” and “Children’s Health Insurance Program”:
- ◆ 12 citations in HealthStar,
 - ◆ 4 citations in MEDLINE, and
 - ◆ 37 citations in GenMed.

50. “Outcomes” and “TANF”:
- ◆ 2 citations in HealthStar,
 - ◆ 1 citations in MEDLINE, and
 - ◆ 3 citations in GenMed.
51. “Outcomes” and “WIC”:
- ◆ 21 citations in HealthStar,
 - ◆ 46 citations in MEDLINE, and
 - ◆ 130 citations in GenMed.
52. “Outcomes” and “School-Based Health Centers”:
- ◆ 11 citations in MEDLINE.
53. “Outcomes” and “Head Start”:
- ◆ 6 citations in MEDLINE.
54. “Outcome” and “Food Stamps”:
- ◆ 13 citations in MEDLINE.
55. “Pilot project” and “EPSDT”:
- ◆ 5 citations in HealthStar.
56. “Pilot project” and “EPSDT” and “Evaluation”:
- ◆ 2 citations in MEDLINE.
57. “Pilot project” and “Medicaid”:
- ◆ 110 citations in HealthStar, and
 - ◆ 84 citations in GenMed.
58. “Pilot project” and “Medicaid” and “Evaluations”:
- ◆ 22 citations in MEDLINE.
59. “Pilot project” and “CHIP”:
- ◆ 0 citations in HealthStar,
 - ◆ 0 citations in MEDLINE, and
 - ◆ 1 citation in GenMed.

60. “Pilot project” and “TANF”:
- ◆ 0 citations in HealthStar,
 - ◆ 0 citations in MEDLINE, and
 - ◆ 0 citations in GenMed.
61. “Pilot project” and “WIC”:
- ◆ 3 citations in HealthStar,
 - ◆ 2 citations in MEDLINE, and
 - ◆ 7 citations in GenMed.
62. “Pilot project” and “Head Start”:
- ◆ 3 citations in MEDLINE.
63. “Pilot project” and “Food Stamp”:
- ◆ 0 citations in MEDLINE.
64. “Demonstration” and “EPSDT”:
- ◆ 1 citation in HealthStar,
 - ◆ 1 citation in MEDLINE, and
 - ◆ 31 citations in GenMed.
65. “Demonstration” and “Medicaid”:
- ◆ 81 citations in HealthStar, and
 - ◆ 490 citations in GenMed.
66. “Demonstration” and “Medicaid” and “Evaluation”:
- ◆ 26 citations in MEDLINE.
67. “Demonstration” and “Children’s Health Insurance Program”:
- ◆ 4 citations in HealthStar,
 - ◆ 0 citations in MEDLINE, and
 - ◆ 14 citations in GenMed.
68. “Demonstration” and “TANF”:
- ◆ 0 citations in HealthStar,
 - ◆ 0 citations in MEDLINE, and
 - ◆ 5 citations in GenMed.

69. “Demonstration” and “WIC”:
- ◆ 4 citations in HealthStar,
 - ◆ 6 citations in MEDLINE, and
 - ◆ 44 citations in GenMed.
70. “Demonstration” and “Head Start”:
- ◆ 1 citation in MEDLINE.
71. “Demonstration” and “Food Stamp”:
- ◆ 0 citations in MEDLINE.
72. “Demonstration” and “Immunization” and “Evaluation”:
- ◆ 30 citations in MEDLINE.
73. “Demonstration” and “School-Based Health Centers”:
- ◆ 0 citations in MEDLINE.
74. “Enrollment” and “EPSDT”:
- ◆ 2 citations in MEDLINE.
75. “Enrollment” and “Children’s Health Insurance Program”:
- ◆ 0 citations in CINAHL.
76. “Enrollment” and “WIC”:
- ◆ 18 citations in CINAHL.
77. “Enrollment” and “WIC” and “Evaluation”:
- ◆ 1 citation in CINAHL.
78. “Enrollment” and “Medicare” and “Evaluation”:
- ◆ 22 citations in MEDLINE, and
 - ◆ 3 citations in CINAHL.
79. “Enrollment” and “CHIP”:
- ◆ 5 citations in MEDLINE, and
 - ◆ 6 citations in CINAHL.
80. “Enrollment” and “Outreach” and “WIC”:
- ◆ 3 citations in CINAHL.

81. “Enrollment” and “TANF”:
♦ 0 citations in MEDLINE.
82. “Enrollment” and “Food Stamps”:
♦ 4 citations in MEDLINE, and
♦ 10 citations in CINAHL.
83. “Enrollment” and “School” and “Lunch”:
♦ 0 citations in CINAHL.
84. “Enrollment” and “Head Start”:
♦ 2 citations in MEDLINE.
85. “Outreach” and “WIC”:
♦ 11 citations in CINAHL.
86. “Outreach” and “CHIP”:
♦ 11 citations in CINAHL.
87. “Outreach” and “Children’s Health Insurance Program”:
♦ 0 citations in CINAHL.
88. “Outreach” and “School” and “Lunch”:
♦ 0 citations in CINAHL.
89. “Outreach” and “Food Stamps”:
♦ 7 citations in CINAHL.
90. “Outreach” and “Marketing”:
♦ 21 citations on MEDLINE.
91. “Medicaid” and “Outreach”:
♦ 21 citations in CINAHL.

APPENDIX C:
INTERNET SOURCES USED FOR THE LITERATURE SEARCH

INTERNET SOURCES USED FOR THE LITERATURE SEARCH

Internet searches were performed primarily to locate research in progress and unpublished government-sponsored evaluation reports.

◆ Search Engines:

- ◇ LookSmart.com,
- ◇ Snap.com,
- ◇ About.com,
- ◇ Netscape.com,
- ◇ HotBot.com,
- ◇ Yahoo.com,
- ◇ Lycos.com, and
- ◇ ExciteToGo.com.

◆ Government Websites:

- ◇ Centers for Disease Control,
- ◇ Internal Revenue Service (EITC),
- ◇ National Institute of Health (NIH),
- ◇ Social Security Administration (SSA),
- ◇ SCHIP websites (all states with websites),
- ◇ U.S. Department of Agriculture (USDA):
 - Food and Nutrition Service.
- ◇ U.S. Department of Education,
- ◇ U.S. Department of Health and Human Services:
 - Administration for Children and Families (ACF),
 - Health Care Financing Administration (HCFA), and
 - Health Resources and Services Administration (HRSA).
- ◇ U.S. General Accounting Office, and
- ◇ The White House.

◆ Advocacy Websites:

- ◇ Center on Budget and Policy Priorities,
- ◇ Children's Defense Fund,
- ◇ Families USA,
- ◇ Family Voices,
- ◇ March of Dimes,
- ◇ National Association for Child Advocacy,
- ◇ Southern Institute for Children and Families, and
- ◇ Children's Health Fund.

- ◆ Association Websites:
 - ◇ American Public and Human Services Association,
 - ◇ National Governors' Association, and
 - ◇ National Governors' Association for Best Practices.

- ◆ Foundation Websites:
 - ◇ Annie E. Casey Foundation,
 - ◇ California Health Care Foundation,
 - ◇ David and Lucile Packard Foundation,
 - ◇ Flinn Foundation,
 - ◇ Jewish Foundation,
 - ◇ Henry J. Kaiser Family Foundation,
 - ◇ Robert Wood Johnson Foundation, and
 - ◇ W. K. Kellogg Foundation.

- ◆ Organizations/Centers/Health Services Research Websites:
 - ◇ Abt Associates,
 - ◇ Alpha Center,
 - ◇ American Academy of Family Physicians,
 - ◇ American Academy of Pediatrics,
 - ◇ Commonwealth Fund,
 - ◇ Family Health Outcomes Project, UCSF,
 - ◇ Mathematica Policy Research, Inc.,
 - ◇ Maternal and Child Health Policy Research Center,
 - ◇ National Center for Education on Maternal and Child Health,
 - ◇ Institute for Child Health Policy,
 - ◇ Institute for Research on Policy,
 - ◇ Joint Centers for Poverty Research,
 - ◇ Rand Institute, and
 - ◇ Robert Wood Johnson (RWJ) Covering Kids.

- ◆ Social Marketing Websites:
 - ◇ Health Canada,
 - ◇ Prospect Associates, and
 - ◇ Weinreich Communications.

APPENDIX D:
EXPERTS, STATE CHIP DIRECTORS, AND STATE PUBLIC ASSISTANCE
AGENCIES CONSULTED FOR LITERATURE REVIEW

EXPERTS, STATE CHIP DIRECTORS, AND STATE PUBLIC ASSISTANCE AGENCIES CONSULTED FOR LITERATURE REVIEW¹

Contacts were made primarily to locate research in progress and unpublished government-sponsored evaluation reports, but we also requested information on published evaluation reports or articles to help ensure the thoroughness of our search.

- ◆ Ann Bacharach, Pennsylvania Partnership for Children
- ◆ Keith Cherry, Westat, Inc.
- ◆ Sarah Clark, University of Michigan Medical Center
- ◆ Susan Cypert, Arizona Health Care Cost Containment System
- ◆ David Dearborn, Connecticut Department of Social Services
- ◆ Lisa Dubay, The Urban Institute
- ◆ Norma Everett, Delaware Department of Health and Social Services
- ◆ Carolyn Holmes, Seniors Research Group
- ◆ Dana Hughes, Institute for Health Policy Studies
- ◆ Tom Kelly, Annie E. Casey Foundation
- ◆ Allison Kemp, Children's Hospital Research Institute
- ◆ Genevieve Kenney, Urban Institute
- ◆ Jennie Kronenfeld, Department of Sociology, Arizona State University
- ◆ Deborah Lurie, Porter Novelli
- ◆ Nora Maloy, Blue Cross and Blue Shield of Michigan Foundation
- ◆ Daniel McGoldrick, National Campaign for Tobacco Free Kids
- ◆ Janet Mitchell, Center for Health Economics Research
- ◆ Mary Ann Nadzio, Delaware Department of Health and Social Services
- ◆ Rose Naff, Florida Healthy Kids Corporation

¹ We attempted to reach the following people but were unable to: Wendy Blackmon, Alabama Department of Public Health; Mary Brecht Carpenter, National Center for Education of Maternal and Child Health; Randy Brown, Mathematica Policy Research, Inc.; Carole Bryant, University of South Florida; Pat Chaulk and Cindy Guy, Annie E. Casey Foundation; Donna Cohen Ross, Center on Budget and Policy Priorities; Leslie Cummings, California Department of Health Services; Elsie Eyer, Arizona Department of Health Services; Moe Gallegos, Arizona Family Assistance Administration; Doug Greenway, National Association of WIC Directors; Roy Jeffus, Arkansas Division of Medicaid; Bill Johnson, Arizona State University; Craig Lefebvre, Prospect Associates; Mike Murphy, Alabama Department of Public Health; Glen Novak, Centers for Disease Control and Prevention; Chris Prue, Centers for Disease Control and Prevention; Helen Raikes, Administration on Children, Youth, and Families; Alicia Rodriguea, U.S. Department of Agriculture; Cassie Sawr, Children's Action Alliance; Bob Sharpe, Florida's Agency for Health Care Administration; Louisa Tarulla, Administration on Children, Youth, and Families; and Bob Valdez, Inter-University Program for Latino Research and Rand Institute.

- ◆ William Novelli, National Campaign for Tobacco Free Kids
- ◆ Jeannette O'Connor, Children's Defense Fund
- ◆ Michael Perry, Lake Sosin Snell Perry and Associates
- ◆ Vicky Pulos, Families USA Foundation
- ◆ Bill Read, Flinn Foundation
- ◆ Mike Richards, Massachusetts Division of Medical Assistance
- ◆ Margo Rosenbach, Mathematica Policy Research, Inc.
- ◆ Thomas Rundall, University of California, Berkeley, School of Public Health and the Institute for Health Policy Studies
- ◆ Joel Sanders, Alabama Department of Human Resources (TANF Division)
- ◆ Gayle Sandlin, Alabama Department of Public Health
- ◆ David Sandman, Commonwealth Fund
- ◆ Elizabeth Shenkman, Institute for Child Health Policy
- ◆ Deborah Smith, Alaska Department of Health and Social Services
- ◆ Robert St. Peter, Kansas Health Institute
- ◆ Sharyn Sutton, Sutton Social Marketing
- ◆ Katherine Swartz, Harvard University School of Public Health
- ◆ Peter Szilagyi, University of Rochester School of Medicine
- ◆ Howard Taras, American Academy of Pediatrics (San Diego)
- ◆ Christine Tollestrup, University of New Mexico Health Science Center
- ◆ Edward Trapido, University of Miami
- ◆ Susan Tyler, Colorado Plus Health Plan
- ◆ Frank Ullman, Urban Institute
- ◆ Judy Walruff, Flinn Foundation
- ◆ Joie Wallis, Arkansas Department of Human Services

APPENDIX E:

TABLE 6. PARTIAL EVIDENCE TABLE OF EVALUATION STUDIES IN PROGRESS

Table 6. Partial Evidence Table of Evaluation Studies In Progress

Study Identification	<u>Evaluation of the First Things First Initiative</u> . University of California, Berkeley School of Public Health, Center for Health Management Studies, in collaboration with the Institute for Health Policy Studies, University of California at San Francisco; contact Thomas G. Rundall, Berkeley School of Public Health
Study Sponsor	California HealthCare Foundation and University of California, Berkeley School of Public Health, Center for Health Management Studies
Research Objective	Assess the effectiveness of the 10 First Things First (FTF) community coalitions' outreach approaches to increasing Medi-Cal (California's Medicaid program) enrollment; improve the capacity of the 10 community coalitions to increase enrollment of eligible children in Medi-Cal through feedback of process findings in a timely manner. The goals of the community coalitions were to: <ul style="list-style-type: none">◆ Engage families of Medi-Cal eligible children,◆ Identify barriers to enrollment,◆ Reduce or eliminate those barriers, and◆ Increase actual enrollment of children in Medi-Cal.
Study Timeframe	April 1, 1998 – September 20, 1999
Study Population	Grants awarded to local outreach coalitions in 10 communities. Coalition partners include schools, public agencies, health and social service providers, community organizations, faith community, and target potentially Medi-Cal eligible children in: <ul style="list-style-type: none">◆ Densely populated/urban areas,◆ Mix of urban, suburban, rural areas, or◆ Sparsely populated areas.
Intervention(s)	Case management/advocacy: <ul style="list-style-type: none">◆ Outreach workers employ a variety of strategies to contact and enroll families; three primary strategies employed are:<ul style="list-style-type: none">◇ Liaisoning with key community institutions by providing them with written materials and conducting workshops,◇ Attending community events (health and neighborhood fairs and ethnic celebrations; providing advice about the Medi-Cal system; distributing fact sheets, advertising flags, and information cards),◇ Making person-to-person contacts (home visits, train-the-trainers, one-on-one contact at community health clinics and schools).

Table 6. Partial Evidence Table of Evaluation Studies In Progress

Method(s)*	<p>Mixed methods:</p> <ul style="list-style-type: none"> ◆ Case study design and cross-case analysis: Much of the FTF evaluation requires qualitative analysis of data. Standard classification techniques for qualitative data will be used to analyze the responses of various key respondents to key process evaluation questions. The use of multiple data sources, multiple investigators, and multiple methods of investigation will enable researchers to triangulate data for the purpose of corroborating the events and processes relating to the FTF projects. Case studies for each site will be reviewed by key FTF program staff. Researchers will also use classification and pattern-matching techniques based on Yin (1994) to perform cross-case analysis. Responses will be analyzed to identify cross-case “themes and variations.” ◇ Data collection: Attendance at state-wide FTF Conference in June 1998; review of grantee FTF proposals; site visits to each FTF community; monthly telephone conference calls with FTF staff at each site; review of grantee-provided written materials; quarterly data reports from the grantees; bi-weekly evaluation team meetings; focus group discussion; surveys of key coalition and community members at each site. ◆ Descriptive statistics (with statistical tests for significance): <ul style="list-style-type: none"> ◇ Assess secular trend with respect to Medi-Cal enrollments of children through examination of plots of monthly enrollments of children in Medi-Cal in the 10 FTF communities from 4/1/96-3/3/98, ◇ Assess changes in Medi-Cal enrollments of children in FTF communities before and after implementation of the FTF program (4/1/98-9/30/99) through bivariate and multivariate techniques, ◇ Data collection: Monthly enrollments of children in Medi-Cal in the FTF communities from 4/1/96 to 9/30/99, obtained from California’s Medi-Cal office.
Outcome(s) Measured	<ul style="list-style-type: none"> ◆ Process evaluation measures in 10 FTF sites: <ul style="list-style-type: none"> ◇ Number of potential applicants contacted by the FTF project, ◇ Number of applications completed and submitted to Medi-Cal, ◇ Number of applicants contacted who were eligible, ◇ Number of applicants denied and reasons for denials (including referral to other programs), ◇ Number of Medi-Cal recipients disenrolled and reasons for disenrollment. ◆ Outcome evaluation measures: <ul style="list-style-type: none"> ◇ Monthly enrollments of children in Medi-Cal in 10 FTF communities from 4/1/96-9/30/99, ◇ Number of applicants in 10 FTF communities contacted who were enrolled for the first time, ◇ Number of re-enrollments facilitated by FTF program.
Scheduled Completion of Findings	March 1, 2000

* The original study design intended to compare the 10 FTF communities with 6 comparable non-FTF communities to help control for confounding factors. However, the uniqueness of the FTF communities and the specific target populations within each of these communities made it impossible to identify truly equivalent communities to use as comparison groups.

Table 6. Partial Evidence Table of Evaluation Studies In Progress

Study Identification	Evaluation of Outreach and Promotion Activities Related to Increasing Participation Among Hispanic/Latino Children in NJKidcare in Hudson County, NJ. Barents Group, LLC; contact Lisa Green or Kenneth Cahill
Study Sponsor	Health Care Financing Administration
Research Objective	Assess the effectiveness of a community-level approach to increasing enrollment in SCHIP programs (NJKidcare is New Jersey's SCHIP program); relative assessment of effectiveness of community-based outreach worker activities for increasing SCHIP enrollment
Study Timeframe	January 1, 2000 – April 1, 2000
Study Population	All children under 19 years of age in Hudson County (outcomes will be analyzed by age, race/ethnicity, and NJKidcare program components – A, B, C, or D)
Intervention(s)	<p>Case management/advocacy:</p> <ul style="list-style-type: none">◆ Six community-based outreach worker grants to identify potentially eligible children, increase awareness of the NJKidcare program, and facilitate enrollment in the program (50% of funding dependent on meeting application targets),◆ School-based identification of potentially eligible children through screener sent home to all children, returned to school, followed-up by application sent to families who may be eligible, and matching of these families to the community-based outreach workers to assist with application completion and follow-up if needed,◆ Public relations activities to raise awareness of NJKidcare and availability of outreach worker assistance through press conferences, radio remotes (via Spanish-language radio stations, health fairs, give-aways), and “earned media” approach (i.e., create media interest through other outreach activities).
Method(s)	<p>Descriptive statistics (with statistical tests for significance):</p> <ul style="list-style-type: none">◆ NJKidcare enrollment in Hudson County, NJ, will be compared with enrollment in comparison Passaic County, NJ over study period through differences of proportions and means tests for matched samples; change in NJKidcare enrollment in Hudson County NJ before and after implementation of the community-level approach will be assessed, through chi-square and t-tests; descriptive statistics calculated for number of potentially eligible children enrolled in NJKidcare after implementation of community-level approach.<ul style="list-style-type: none">◇ Data collection: Baseline number of Hispanic/Latino children potentially eligible for NJKidcare in Hudson County, NJ, estimated by NJ's Medicaid Department of Statistics; contacts and applications sent in by activity collected from outreach worker monthly activity reports; enrollment by outreach worker activity and for comparison community collected from NJKidcare agency.

Table 6. Partial Evidence Table of Evaluation Studies In Progress

Outcome(s) Measured	<ul style="list-style-type: none"> ◆ Community-based outreach worker activities: <ul style="list-style-type: none"> ◇ How many children/families reached, by activity, ◇ How many applications filled out and sent to NJKidcare office, by activity, ◇ How many children enrolled in NJKidcare programs, by activity (through coded applications). ◆ School-based activities: <ul style="list-style-type: none"> ◇ Number of children identified as potentially eligible for NJKidcare. ◆ Public relations activities: <ul style="list-style-type: none"> ◇ Media reach through auditing of press coverage of PR activities, ◇ Number of radio remotes held.
Scheduled Completion of Findings	April 15, 2000

Table 6. Partial Evidence Table of Evaluation Studies In Progress

Study Identification	Evaluation of the Seek-Find-Enroll Initiative. Contact Jack Wheeler, School of Public Health, University of Michigan, or Gary Freed, Division of General Pediatrics, University of Michigan Medical Center
Study Sponsor	Blue Cross Blue Shield (BCBS) of Michigan Foundation
Research Objective	Assess the most effective means for identifying and enrolling children in Michigan's Medicaid ("Healthy Kids") and SCHIP ("MICHild") programs through community coalitions and, to the extent possible, determine whether activities funded under the BCBS grant have increased enrollment in the targeted communities compared with comparable communities that did not receive BCBS funding*
Study Timeframe	February 1999 – June 2001
Study Population	14 grantees funded, with diverse target populations: <ul style="list-style-type: none"> ◆ Hispanic/Latino families, ◆ Arab American families, ◆ American Indian families, ◆ Families in rural areas, ◆ Families of children with special needs, ◆ Families in general with potentially eligible children.
Intervention(s)	Case management/advocacy: <ul style="list-style-type: none"> ◆ 14 community coalitions funded to identify potentially eligible children, increase awareness of the MICHild and Healthy Kids programs, and facilitate enrollment in the programs, ◆ Grantees employ a variety of activities, including "bounty system" of paying teen recruiters per enrolled child; use of portable photocopier for home application assistance; door-to-door outreach by volunteer "community ambassadors"; telephone hot-line; direct application assistance and follow-up; training of health providers and community health advocates; out-stationing of outreach workers; development of bi-lingual educational and presentation materials; school- and church-based activities; advertisements such as posters on public buses.
Method(s)	Mixed methods: <ul style="list-style-type: none"> ◆ Case study design: Data collection will be through site visits to 14 project sites, self-assessment from community coalitions about which activities appear to be most effective and community characteristics that may have affected activity effectiveness, and records of activities from community coalition staff. Activities records will include number of individuals/families contacted or in attendance at an activity, the types of partnerships that have been formed by the community coalition, number of and places where coalitions have given presentations, number of flyers distributed, number of applications completed, etc. The evaluation will mainly focus on processes, but to the extent possible, will try to associate activities with enrollment. There is no mechanism at the state level to link enrolled individuals to a particular community coalition or a particular activity; however, coalitions are trying to track enrollment of clients when coalition is aware that client has been enrolled. Data will also be collected from comparable non-BCBS funded communities on the types of enrollment activities in those communities, particularly formation of coalitions, to determine whether the BCBS funding increased enrollment activities and stimulated coalition formation.

Table 6. Partial Evidence Table of Evaluation Studies In Progress

	<ul style="list-style-type: none"> ◆ Descriptive statistics (with statistical tests for significance): In conjunction with the Urban Institute, data from the 1997 and 1999 National Survey of America's Families will be used to establish the number of children potentially eligible for MICHild and Healthy Kids in Michigan. Monthly enrollments in MICHild and Healthy Kids from January 1998 to the present will also be collected from the state. Depending on the quality of the survey data and its geographic precision (e.g., the reliability of county level data), community coalition activities will be linked to enrollment rates at the appropriate geographic level (some coalitions cover many counties and some only cover part of a county or even part of a city).
Outcome(s) Measured	<ul style="list-style-type: none"> ◆ Enrollment rates in MICHild and Healthy Kids (to the extent possible), ◆ Enrollments in MICHild and Healthy Kids from the community coalitions (to the extent possible), ◆ Process measures: Number of individuals contacted, number of flyers distributed, number of presentations given, number of clients provided with application assistance, number of completed applications, etc.
Scheduled Completion of Findings	December 2001

*In some sites, one or more members of the community coalition received funding from sources other than the Blue Cross Blue Shield of Michigan Foundation to facilitate enrollment in Michigan's Medicaid and SCHIP programs.

Table 6. Partial Evidence Table of Evaluation Studies In Progress

Study Identification	<u>Evaluation of Four Pilot Projects to Increase SCHIP and Medicaid Enrollment in Pennsylvania Under the Children's Health Coverage Campaign. Pennsylvania's Partnership for Children; contact Ann Bacharach</u>
Study Sponsor	Robert Wood Johnson (RWJ) Foundation Covering Kids Initiative with support from the Health Alliance Charitable Foundation
Research Objective	Assess the effectiveness of outreach and enrollment efforts through two different models of community-based outreach (the "coalition" model and the "community health worker" model)*
Study Timeframe	September 1999 – December 1999
Study Population	Families with children eligible for Pennsylvania's SCHIP or Medicaid programs in 4 pilot sites
Intervention(s)	<p>Case management/advocacy:</p> <ul style="list-style-type: none"> ◆ "Coalition Building" model of outreach and enrollment: <ul style="list-style-type: none"> ◇ Philadelphia Coalition for Children and Youth (PCCY), a community-based organization in the Southeastern region of the state, chairs one coalition that serves five counties—Philadelphia, Bucks, Chester, Delaware, and Montgomery. PCCY uses an enrollment fund with 10 other participating agencies that receive a \$25 fee, but all the members of the coalition collaborate on outreach and enrollment training, program identification, and problem solving. ◇ In Fayette, Washington, and Greene Counties, there is a coalition of human service and family support agencies. In each coalition, there are at least 12 to 14 agencies such as local health care providers, county assistance offices, the SCHIP insurers, Crime Victims services, school personnel, and Healthy Start providers who are volunteers and receive support from Cornerstone Care staff, a Federally Qualified Health Center (FQHC), and the pilot organization in the Southwestern region of the state. None of these agencies have dedicated staff but are doing outreach and enrollment as part of their regular activities with families. ◆ "Community health worker (CHW)" model of outreach and enrollment: <ul style="list-style-type: none"> ◇ CHWs directly assist families with the application process in two sites in Pennsylvania (York and Allegheny Counties). ◇ Two CHWs in York meet with families in family centers, doctor's offices, schools and family's homes to complete the forms; they also participate in health fairs, Fireman's Festivals and other large group gatherings. ◇ In Allegheny County, the two CHWs provide direct assistance to families at identified sites throughout Allegheny County such as family centers, Head Start sites, and community centers; CHWs also provide training on enrollment to other family-service agencies and provide technical support on difficult issues.
Method(s)	<p>Case study design varies by site:</p> <ul style="list-style-type: none"> ◆ PCCY plans to check every tenth name submitted to the enrollment fund. ◆ In the other three sites, each pilot will follow up with the SCHIP insurers and the County Assistance Office of the family to determine the outcome of application.

Table 6. Partial Evidence Table of Evaluation Studies In Progress

Outcome(s) Measured	<ul style="list-style-type: none"> ◆ SCHIP and Medicaid enrollments tied to each model/project site, ◆ Barriers to enrollment, ◆ Problems with the enrollment process.
Scheduled Completion of Findings	March 1, 2000 (Year 1 report); March 1, 2001 (Year 2 report); the focus group report will be available in the second quarter of Year 2

*Evaluating the two outreach models is just one component of this Covering Kids Initiative. The RWJ Covering Kids Initiative calls for PCCY, the lead organization of this initiative, and the four pilot sites to: simplify and coordinate the two health insurance programs in Pennsylvania, develop and test innovative outreach and enrollment strategies, and replicate successful efforts in other regions in the state.

Table 6. Partial Evidence Table of Evaluation Studies In Progress

Study Identification	<u>Evaluation of the Health-insurance Access Through Schools: “HATS” Project</u> . School Health and Community Pediatrics Division, University of California-San Diego; contact Howard Taras
Study Sponsor	Wyeth-Ayerst Pharmaceuticals and University of California's Policy Center
Research Objective	Assess the use of schools as vehicles to reach low-income families with uninsured children who are eligible for Medicaid and SCHIP programs; assess the use of schools as a way to teach parents about the importance of health insurance and how to use preventive benefits offered by insurance plans; develop a school-based outreach and application “formula” that can be replicated in other school districts
Study Timeframe	November 1998 – January 2000
Study Population	Uninsured school-age children potentially eligible for Medicaid and SCHIP programs in California
Intervention(s)	Case management/advocacy: <ul style="list-style-type: none"> ♦ Use of school-based outreach workers/application assistants, who are given access to schools’ lists of parents likely to be interested in Medicaid and SCHIP programs; telephone these parents, send fliers home with children, go to open houses, work with Parent-Teacher organizations and school nurses, invite parents to come to school for application assistance, photocopy and mail applications on behalf of parents, help parents in their communications with government eligibility and application-processing agencies when necessary.
Method(s)	Case study design: <ul style="list-style-type: none"> ♦ Case studies of selected pilot sites (20 schools in 4 school districts in San Diego County), ♦ Study will involve the collection and analysis of qualitative process evaluation information, survey data, and quantitative data on outcome measures, ♦ For first 130 families recruited in 3 schools (in 2 school districts), a more comprehensive evaluation will be done.
Outcome(s) Measured*	<ul style="list-style-type: none"> ♦ Number of hours of outreach work, and number of visits or calls by outreach worker, required to complete an application, ♦ Proportion of parents who begin, but do not complete the application process, and reasons for non-completion, ♦ Number of applications completed, ♦ Number of children enrolled in Medicaid or SCHIP, ♦ For 130 families (with more comprehensive evaluation), additional outcome measures are: parents recall of education on primary care and managed care, use of insurance measured by attainment of recent preventive “well-child” examination, reasons for children <i>not</i> being insured, and feasibility of obtaining school absenteeism data related to illness.
Scheduled Completion of Findings	April 2000

*A number of other access to care and utilization measures will be collected and used in the evaluation of the project, but are not relevant to this literature review.

Table 6. Partial Evidence Table of Evaluation Studies In Progress

Study Identification	Testing Outreach and Enrollment Strategies for Insuring Low-Income Children in New York City. Medical and Health Research Association of New York City; contact David Sandman
Study Sponsor	The Commonwealth Fund
Research Objective	Assess the effectiveness of two different outreach and enrollment strategies to enroll eligible uninsured children in New York's SCHIP (Child Health Plus) program and Medicaid
Study Timeframe	November 1998 – June 1999
Study Population	WIC clients whose children are uninsured and potentially eligible for Child Health Plus (CHP) or Medicaid, and small business owners/employees where uninsured children may be eligible for CHP or Medicaid
Intervention(s)	<p>Case management/advocacy:</p> <ul style="list-style-type: none"> ◆ MHRA, which administers the WIC program in New York, placed employees in three WIC centers in Brooklyn (the “WIC Center Model”) or in a small business that participates in WIC on a contract basis with New York (the “Small Business Model”). ◆ In the WIC Center Model, MHRA employees acted as facilitators to identify, educate, and help enroll children in CHP and Medicaid. MHRA employees, who can determine eligibility, were also placed in Brooklyn WIC-contracting businesses to help enroll eligible children. Participating businesses were asked to help improve awareness of public insurance programs. ◆ MHRA employees participating in both models tracked the number of applications completed and the number of applications approved.
Method(s)	<p>Descriptive statistics (with statistical tests for significance):</p> <ul style="list-style-type: none"> ◆ Descriptive statistics and statistical tests will be conducted for a pre- and post- survey of 1,811 WIC clients in Brooklyn and Queens boroughs (each survey had a sample size of approximately 900). Survey results will be used to assess differences in Medicaid/CHP program awareness and enrollment before and after the interventions. Survey results will also be used to assess differences in awareness and enrollment between Brooklyn, which had the interventions, and a comparison site in Queens that had no intervention. The different models will also be linked to the number of applications completed and the number of applications approved.
Outcome(s) Measured	<ul style="list-style-type: none"> ◆ Number of CHP and Medicaid applications completed, ◆ Number enrolled in CHP program or Medicaid, ◆ Awareness of CHP/Medicaid program, ◆ Satisfaction with Medicaid/CHP among new enrollees, ◆ Ratings of enrollment assistance provided by MHRA.
Scheduled Completion of Findings	March 2000

Table 6. Partial Evidence Table of Evaluation Studies In Progress

Study Identification	<u>Evaluation of RWJ Covering Kids Pilot Projects in California</u> . University of California-San Diego, Center for Child Health Outcomes; contact Kim Dennis
Study Sponsor	Community Health Council Grant
Research Objective	Develop a data collection methodology and process for evaluating pilot projects in San Francisco and Lake County, California. Client intake and client encounter forms have been designed to track the number of applications completed, the number of individuals enrolled, and the number of hours for an outreach worker to complete an application
Study Timeframe	The two pilot projects began in May 1999 and end in May 2002. The evaluation began in July 1999 and will end with the end of the projects
Study Population	Families of children eligible for SCHIP/Medicaid (Medi-Cal) in the two counties*
Intervention(s)	Case management/advocacy: <ul style="list-style-type: none"> ◆ Visits by a trained outreach worker to the homes of potentially eligible children is the primary intervention in Lake County. Lake County is a rural county in which access to transportation is often a barrier. ◆ San Francisco county intervention is more complex, involving a number of collaborators in identifying eligible children, training workers, and providing one-on-one assistance to complete applications.
Method(s)	Mixed methods: <ul style="list-style-type: none"> ◆ Case studies of the pilot sites using common data-gathering mechanism, ◆ Descriptive statistics (without statistical tests for significance).
Outcome(s) Measured	<ul style="list-style-type: none"> ◆ Number of completed applications, ◆ Number enrolled, ◆ Estimated cost per completed application.
Scheduled Completion of Findings	Data for 1999 should be compiled and analyzed by summer 2000

* The school-based project directed by Dr. Howard Taras, described separately in this table, is also an RWJ Covering Kids pilot.

Table 6. Partial Evidence Table of Evaluation Studies In Progress

Study Identification	Monitoring and Evaluating the State Children's Health Insurance Program (SCHIP). Urban Institute; contact Ian Hill, Genevieve Kenney, or Lisa Dubay
Study Sponsor(s)	Robert Wood Johnson Foundation, The Packard Foundation, and the Assistant Secretary for Planning and Evaluation (ASPE)-DHHS
Research Objective	For the project component aimed at assessing outreach and enrollment strategies, assess state strategies to increase SCHIP enrollment, with a focus on outreach and enrollment processes; assess two broad strategies: state-wide information and dissemination activities vs. community-based outreach efforts*
Study Timeframe	October 1998 – September 2001
Study Population	National focus, with detailed analyses in up to 18 states
Intervention(s)	State strategies to increase public awareness of SCHIP program: <ul style="list-style-type: none"> ◆ Simplification of application forms, ◆ State-wide information and dissemination activities, ◆ Community-based outreach efforts.
Method(s)	<ul style="list-style-type: none"> ◆ Case study design: <ul style="list-style-type: none"> ◇ Findings from case studies in up to 18 states will be presented in a series of qualitative reports. ◇ Site visit data collection is through structured interviews in several communities in each state with state policy officials/agencies; the governor's policy office; state legislators; county social services agencies including the local Medicaid office and a county eligibility worker; child advocacy groups; Title V staff; community health clinics and Medicaid providers; enrollment brokers; HMOs; and the RWJ Covering Kids grantee(s) in the state. ◇ Interviewees will be asked their opinions on which strategies are most effective and why. State SCHIP program information will also be collected with a focus on measures to simplify the application process such as mail-in forms, eliminating the assets test, out-stationing eligibility workers, and shortening the application form. ◆ Quantitative Analyses: <ul style="list-style-type: none"> ◇ Analyses of the National Survey of America's Families (NSAF) will be conducted nationally and separately in 13 states that together account for over one-half of the nation's children, to assess the extent to which eligible children participate in public programs, how knowledgeable parents are about Medicaid and SCHIP, the experiences they have had with the enrollment process, and parents' views on welfare.
Outcome(s) Measured	<ul style="list-style-type: none"> ◆ Enrollment process and eligibility measures, ◆ SCHIP enrollment.
Scheduled Completion of Findings	A series of reports will be released throughout the period of study

*The study will address additional research objectives not relevant to this literature review. Findings from the qualitative and quantitative research will be published in a series of reports that focus on cross-cutting issues.

Table 6. Partial Evidence Table of Evaluation Studies In Progress

Study Identification	<u>Medicaid vs. Premium Subsidy: Oregon's CHIP Alternatives</u> . Center for Health Economics Research, Waltham, MA; contact Janet Mitchell
Study Sponsor	Agency for Healthcare Research and Quality, the David and Lucile Packard Foundation, Health Resources and Services Administration
Research Objective	Assess whether and how parents heard about either Oregon's SCHIP Medicaid-look-alike program or its premium subsidy program*
Study Timeframe	2000
Study Population	Parents of low-income children eligible for SCHIP programs in Oregon, with an oversampling of the Hispanic/Latino population
Intervention(s)	A variety of state outreach activities
Method(s)	Descriptive statistics (with statistical tests for significance) and multivariate regression design: <ul style="list-style-type: none">◆ Responses from a telephone survey of a random sample of 600 parents in each of three groups will be analyzed:<ul style="list-style-type: none">◇ Parents of children enrolled in Oregon's SCHIP Medicaid-look-alike program,◇ Parents of children enrolled in Oregon's SCHIP premium subsidy program,◇ Parents of children eligible for either program but not enrolled.
Outcome(s) Measured	For parents of enrolled children: How did they hear about the program? For parents of eligible but non-enrolled children: Have they heard about the program and how? Why didn't they enroll their children?
Scheduled Completion of Findings	The findings will be incorporated into the report for the entire 3-year project, with results reported in 2002

*The primary focus of the research under this grant is to compare the access to, satisfaction with, and quality of health care of Oregon children who choose to enroll in the SCHIP Medicaid-look-alike program, those who choose to enroll in the premium subsidy program, and those who remain uninsured. Researchers will also investigate continuity of enrollment and the reasons why some fail to re-enroll in the SCHIP program.

Table 6. Partial Evidence Table of Evaluation Studies In Progress

Study Identification	<u>Evaluation of the New Jersey Access Program</u> . Department of Health Policy and Management, Harvard School of Public Health; contact Katherine Swartz
Study Sponsor	Robert Wood Johnson Foundation
Research Objective	The primary research objective of this grant was to determine if subsidies led to adverse selection in the Health Access New Jersey Program (Access Program)*, a short-lived premium subsidy program. Because adverse selection is not relevant to this literature review, no findings or methodology used to test adverse selection are reported in the partial evidence table. Instead, this table outlines another section of the study which assessed the impact of subsidies on enrollment rates in the Access Program.*
Study Timeframe	June 1996 - August 1997
Study Population	Families with incomes below 250 percent of the poverty level not eligible for Medicaid, Medicare, or employer-based health insurance but who wanted to purchase policies in the state's individual health insurance market, the Individual Health Coverage Program (IHCP)
Intervention(s)	Premium subsidies: <ul style="list-style-type: none"> ◆ Four types of contracts were subsidized under the Access Program: single; married couple; one parent and up to two children; and family (two parents and up to two children). The subsidies allowed families to buy private insurance under the IHCP. Premiums were as follows: <ul style="list-style-type: none"> ◇ \$5 premium per month (\$10 for family policies) for families with incomes below the poverty level, ◇ \$44 premium per month (maximum) for families with incomes between poverty level and 150 percent of poverty level, ◇ \$100 premium per month (maximum) for families with incomes up to 250 percent of the poverty level.
Method(s)	Descriptive statistics (without statistical tests for significance): <ul style="list-style-type: none"> ◆ Data collection: <ul style="list-style-type: none"> ◇ Reviewed data from monthly reports by the Third Party Administrator and the Department of Health. The monthly reports were based on the application and enrollment forms. April 1996 monthly summary enrollment data was used because April is the last month in which enrollment increased and provided the most complete snapshot of enrollees .
Outcome(s) Measured	Enrollment in the Access Program
Scheduled Completion of Findings	Findings are forthcoming in April in the Spring issue of <i>Inquiry</i>

*In December 1995, it was announced that the Access Program was to be converted into "Children First," a program only for children. "Children First" is now known as NJKidCare, New Jersey's SCHIP program. However, adults who retained eligibility and continue to pay premiums can remain enrolled in the original Access Program and are supported by funds in the original state budget.

Table 6. Partial Evidence Table of Evaluation Studies In Progress

Study Identification	<u>Synthesis of State Evaluations of SCHIP Programs</u> . Mathematica Policy Research, Inc.; contact Margo Rosenbach
Study Sponsor	Health Care Financing Administration
Research Objective	Describe the outreach interventions used by states to increase SCHIP enrollment and states' assessment of relative effectiveness of approaches
Study Timeframe	State evaluations are due March 31, 2000
Study Population	State SCHIP programs
Intervention(s)	Outreach activities implemented by state SCHIP agencies
Method(s)	Qualitative methods (specific approach not yet determined): <ul style="list-style-type: none"> ◆ Synthesize the data collected from state evaluations of their SCHIP program. The state "Evaluation Framework" fulfills the evaluation component of SCHIP program funding in which states are required to accurately assess their progress in reducing the number of uninsured low-income children and assuring access to quality health services. The research will focus on categorizing outreach interventions used by states and on their rankings regarding their relative effectiveness.*
Outcome(s) Measured	<ul style="list-style-type: none"> ◆ Outreach interventions used by states to increase SCHIP enrollment, ◆ State ranking of effectiveness of outreach interventions.
Scheduled Completion of Findings	December 2001 (due date for Secretary's Report to Congress)

* State evaluations will be synthesized whether or not they use the "Evaluation Framework."

Table 6. Partial Evidence Table of Evaluation Studies In Progress

Study Identification	Literature Review and Synthesis of Evaluations of Outreach Interventions to Increase Enrollment in SCHIP Programs. Mathematica Policy Research, Inc.; contact Margo Rosenbach
Study Sponsor	Health Care Financing Administration
Research Objective	Assess the relative effectiveness of outreach activities for increasing enrollment in SCHIP programs
Study Timeframe	Five-year effort, from July 1999 - July 2004
Study Population	SCHIP-eligible populations
Intervention(s)	As reported in the literature reviewed
Method(s)	Literature review and synthesis: <ul style="list-style-type: none">♦ The literature review and synthesis will follow the accepted scientific methodology for conducting this type of research. To the extent possible, the review will include a meta-analysis of findings. Literature reviewed will focus on both published and unpublished studies that are evaluative in nature and assess in a scientifically-rigorous way the impacts of outreach interventions on increased enrollment in SCHIP programs.
Outcome(s) Measured	As reported in the literature reviewed
Scheduled Completion of Findings	Annual reports to HCFA over the 5-year contract period; how the annual reports will be disseminated has yet to be determined by HCFA

Table 6. Partial Evidence Table of Evaluation Studies In Progress

Study Identification	Evaluation of Effectiveness of SCHIP Enrollment Processes and Outreach Interventions from the Consumer Perspective. Mathematica Policy Research, Inc.; contact Margo Rosenbach
Study Sponsor	Health Care Financing Administration
Research Objective	Assess SCHIP enrollment processes, effectiveness of outreach activities, effectiveness of outreach messages, etc., as well as reasons for enrollment, disenrollment, or non-enrollment in SCHIP programs, from the consumer's perspective
Study Timeframe	Mid-2001 to Early-2002
Study Population	Families with SCHIP-eligible children in four states
Intervention(s)	Specific interventions to be included in study will be determined by on-going activities in states selected for the study
Method(s)	Case study design/focus groups: <ul style="list-style-type: none">◆ Focus groups will be conducted with families who have children enrolled or potentially-eligible but not enrolled in SCHIP in the selected states and with parents of disenrollees. Interviews will be conducted as part of the case study with state officials, outreach workers, advocates, providers, and others. Findings from the focus groups and structured interviews will be analyzed using the accepted scientific methodology for conducting this type of research.
Outcome(s) Measured	Specific outcomes to be included in study will be determined by on-going activities in states selected for the study
Scheduled Completion of Findings	End of 2002

Table 6. Partial Evidence Table of Evaluation Studies In Progress

Study Identification	Evaluation of the Effectiveness of States' Outreach Efforts on SCHIP Enrollment. Mathematica Policy Research, Inc.; contact Margo Rosenbach
Study Sponsor	Health Care Financing Administration
Research Objective	Assess whether particular state-funded outreach activities or the intensity of state outreach efforts led to a significant increase in SCHIP enrollment in the state
Study Timeframe	2003-2004
Study Population	50 states and the District of Columbia
Intervention(s)	State outreach activities
Method(s)	<p>Multivariate regression design:</p> <ul style="list-style-type: none"> ◆ Data will be collected on each state's outreach activities to enroll eligible children in their SCHIP program, through contacting each state's SCHIP and Medicaid agencies and review of materials. Data will also be collected on state SCHIP enrollment over the period 1998 to 2003 (if available). Outreach activities will either be classified into discrete categories, or an index of state outreach efforts will be constructed, to use as explanatory variables in the multivariate analysis. State-level SCHIP enrollment will be regressed on these variables, as well as other factors that might have increased SCHIP enrollment in the state over the period of the study, to assess the relative impact of state outreach activities on enrollment.
Outcome(s) Measured	SCHIP enrollment in the 50 states and District of Columbia
Scheduled Completion of Findings	Mid-2004

Table 6. Partial Evidence Table of Evaluation Studies In Progress

Study Identification	<u>Evaluation of Florida's SCHIP Program (Kidcare)</u> . University of Florida, Gainesville, FL; contact Elizabeth Shenkman
Study Sponsor	Agency for Health Care Administration, State of Florida
Research Objective	Assess how parents of children enrolled in Florida's SCHIP program (Kidcare) found out about the program; results will be used to help assess relative effectiveness of various state outreach activities for raising program awareness
Study Timeframe	December 1, 1998 - December 31, 1999
Study Population	Children enrolled in Florida's Kidcare program
Intervention(s)	Observational study of Florida's Kidcare program*
Method(s)	Descriptive statistics (with statistical tests for significance): ♦ Descriptive statistics of responses to a telephone survey of a random sample of 4,254 families with children enrolled in Florida's Kidcare program.
Outcome(s) Measured	How families heard about the Kidcare program by race/ethnicity and Kidcare program component among enrollees (for portion of evaluation addressing outreach)
Scheduled Completion of Findings	January 2000** (multivariate analysis of the survey may be released by August 2000)

* The Kidcare program used a variety of outreach strategies as part of its implementation.

** The report was not yet publicly available by the time this literature review was completed. The report includes findings from other aspects of the study that are not reported here because they are not relevant for this literature review.

Table 6. Partial Evidence Table of Evaluation Studies In Progress

Study Identification	<u>Estimates of the Number of Uninsured in Florida</u> . University of Florida, Gainesville, FL; contact Paul Duncan for overall study and Elizabeth Shenkman for Kidcare eligibility estimates
Study Sponsor	State of Florida
Research Objective	Assess whether parents of children eligible for Florida's SCHIP program (Kidcare) had heard of the program, and if so, how they had heard about it; results will be used to help assess relative effectiveness of various state outreach activities for raising program awareness*
Study Timeframe	March 1999 – September 1999
Study Population	People living in Florida
Intervention(s)	A variety of state outreach activities
Method(s)	Descriptive statistics (with statistical tests for significance): <ul style="list-style-type: none"> ◆ Descriptive statistics of responses about household members' insurance status to telephone survey of a random sample of 15,000 people living in Florida, with oversampling in low-income census tracts. As part of the survey, respondents were asked if they knew about Kidcare and if so how.
Outcome(s) Measured	<ul style="list-style-type: none"> ◆ Had person heard of Florida's Kidcare program? ◆ If person had heard of Kidcare, from what source had they heard about it?
Scheduled Completion of Findings	January 2000**

* The primary research objective of the survey was to estimate the number of insured people in Florida. However, the survey also included a component that asked if the person had ever heard of the Kidcare program, and if so, how they had heard about it.

** The report was not yet publicly available by the time this literature review was completed.

Table 6. Partial Evidence Table of Evaluation Studies In Progress

Study Identification	Evaluation of the Effectiveness of Outreach Strategies to Encourage Enrollment in Florida's Kidcare Program for Recent Welfare-to-Work Recipients. University of Florida, Gainesville, FL; contact Elizabeth Shenkman
Study Sponsor	State of Florida's Department of Health
Research Objective	Assess the effectiveness of two specific outreach strategies to encourage women coming off of Florida's Welfare-to-Work program to enroll their children in Florida's SCHIP program (Kidcare)
Study Timeframe	January 2000 – June 2000
Study Population	Women who recently were enrolled in Florida's Welfare-to-Work program who no longer have Medicaid coverage for their children but have not yet enrolled them in Kidcare
Intervention(s)	<ul style="list-style-type: none"> ◆ Direct mailings to inform women of their child's potential eligibility for Kidcare, ◆ A random sample of women will be chosen for door-to-door outreach or possibly other strategies to help them complete a Kidcare application; door-to-door outreach will be conducted by local Healthy Start coalitions.
Method(s)	<p>Descriptive statistics (with statistical tests for significance) and multivariate analysis:</p> <ul style="list-style-type: none"> ◆ Families will be randomly assigned to different intervention strategies, ◆ Telephone surveys will be conducted with a random sample of these women.
Outcome(s) Measured	<p>By randomly-assigned intervention strategies:</p> <ul style="list-style-type: none"> ◆ Number of applications received from those in the study, ◆ Socio-demographic characteristics of the children included in the applications, ◆ Number of approved and denied applications. <p>From telephone surveys:</p> <ul style="list-style-type: none"> ◆ Satisfaction with enrollment process, ◆ Child health status, ◆ Socio-demographic characteristics.
Scheduled Completion of Findings	August 2000